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ABSTRACT

This introductory packet provides an introduction to anxiety problems, framing the discussion within the classification scheme developed by the American Pediatric Association. The variations in degree of problem are discussed with respect to interventions that range from environmental accommodations to behavioral strategies to medication. The packet is divided into six sections. Section 1 highlights the classification of anxiety problems, and specifically the importance of keeping the environment in perspective as a cause of commonly identified psychosocial problems. Sections 2 and 3 provide a discussion of the broad continuum of anxiety problems, as well as a quick overview of some basic resources. Section 4 presents interventions for anxiety problems, including accommodations to reduce anxiety, behavior management and self-instruction, and medication. Section 5 presents additional resource aids. Section 6 concludes with a discussion on keeping anxiety problems in broad perspective. For further information, a set of references, a list of agencies and Web sites, and other resources are included. (GCP)

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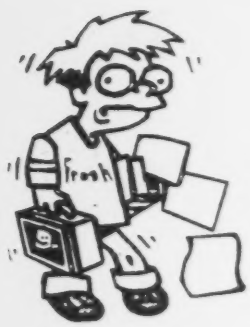
An introductory packet on



Anxiety, Fears, Phobias, and Related Problems: Intervention and Resources for School Aged Youth

This document is a hardcopy version of a resource that can be downloaded from the Center's website (http://smhp.psych.ucla.edu). The Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspice of the School Mental Health Project, Dept. of Psychology, UCLA. Center for Mental Health in Schools, Box 951563, Los Angeles, CA 90095-1563(310) 825-3634 Fax: (310) 206-8716; E-mail: smhp@ucla.edu

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UCLA CENTER FOR MENTAL HEALTH IN SCHOOLS

Under the auspices of the School Mental Health Project in the Department of Psychology at UCLA, our center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. Specific attention is given policies and strategies that can counter fragmentation and enhance collaboration between school and community programs.

MISSION: *To improve outcomes for young people by enhancing policies, programs, and practices relevant to mental health in schools.*

Through collaboration, the center will

- enhance practitioner roles, functions and competence
- interface with systemic reform movements to strengthen mental health in schools
- assist localities in building and maintaining their own infrastructure for training, support, and continuing education that fosters integration of mental health in schools

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Co-directors: Howard Adelman and Linda Taylor
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Website: http://smhp.psych.ucla.edu/

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About the Center's Clearinghouse

The scope of the Center's Clearinghouse reflects the School Mental Health Project's mission -- to enhance the ability of schools and their surrounding communities to address mental health and psychosocial barriers to student learning and promote healthy development. Those of you working so hard to address these concerns need ready access to resource materials. The Center's Clearinghouse is your link to specialized resources, materials, and information. The staff supplements, compiles, and disseminates resources on topics fundamental to our mission. As we identify what is available across the country, we are building systems to connect you with a wide variety of resources. Whether your focus is on an individual, a family, a classroom, a school, or a school system, we intend to be of service to you. Our evolving catalogue is available on request; and available for searching from our website.

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We can provide or direct you to a variety of resources, materials, and information that we have categorized under three areas of concern:

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Among the various ways we package resources are our *Introductory Packets, Resource Aid Packets, special reports, guidebooks*, and *continuing education units.* These encompass overview discussions of major topics, descriptions of model programs, references to publications, access information to other relevant centers, organizations, advocacy groups, and Internet links, and specific tools that can guide and assist with training activity and student/family interventions (such as outlines, checklists, instruments, and other resources that can be copied and used as information handouts and aids for practice).

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- E-mail us at **smhp@ucla.edu**
- FAX us at (310) 206-8716
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- Write School Mental Health Project/Center for Mental Health in Schools, Dept. of Psychology, Los Angeles, CA 90095-1563

Check out recent additions to the Clearinghouse on our Web site: **http://smhp.psych.ucla.edu**

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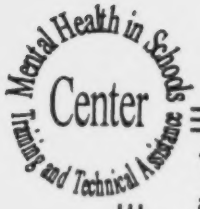
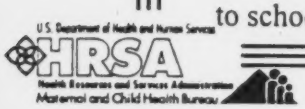


The *Center for Mental Health in Schools* operates under the auspices of the School Mental Health Project at UCLA.* It is one of two *national centers* concerned with mental health in schools that are funded in part by the U.S. Department of Health and Human Services, Office of Adolescent Health, Maternal and Child Health Bureau, Health Resources and Services Administration -- with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (Project #U93 MC 00175).

The UCLA Center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. In particular, it focuses on comprehensive, multifaceted models and practices to deal with the many external and internal barriers that interfere with development, learning, and teaching. Specific attention is given policies and strategies that can counter marginalization and fragmentation of essential interventions and enhance collaboration between school and community programs. In this respect, a major emphasis is on enhancing the interface between efforts to address barriers to learning and prevailing approaches to school and community reforms.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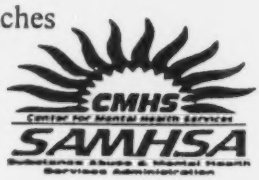

*Co-directors: Howard Adelman and Linda Taylor.
Address: Box 951563, UCLA, Dept. of Psychology, Los Angeles, CA 90095-1563.
Phone: (310) 825-3634 FAX: (310) 206-8716 E-mail: smhp@ucla.edu
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OVERVIEW

In providing an introduction to anxiety problems, a discussion framed within the classification scheme developed by the American Pediatric Association is offered. The variations in degree of problem are discussed with respect to interventions that range from environmental accommodations to behavioral strategies to medication.

For pursuing further information, a set of references, a list of agencies and websites, and other resources are included.

Anxiety, Fears, Phobias, and Related Problems: Interventions and Resources

This introductory packet contains:

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I.Classifying Anxiety Problems: Keeping the Environment in Perspective as a Cause of Commonly Identified Psychosocial Problems

A. Labeling Troubled and Troubling Youth

B. Common Behavior Responses to Environmental Situations and Potentially Stressful Events

C. Fact Sheet: Anxiety Disorders in Children and Adolescents

I. Classifying Anxiety Problems

A large number of students are unhappy and emotionally upset; only a small percent are clinically depressed. A large number of youngsters have trouble behaving in classrooms; only a small percent have attention deficit or a conduct disorder. In some schools, large numbers of students have problems learning; only a few have learning disabilities. Individuals suffering from true internal pathology represent a relatively small segment of the population. A caring society tries to provide the best services for such individuals; doing so includes taking great care not to misdiagnose others whose "symptoms" may be similar, but are caused by factors other than internal pathology. Such misdiagnoses lead to policies and practices that exhaust available resources in ineffective ways. A better understanding of how the environment might cause problems and how focusing on changing the environment might prevent problems is essential.

A. Labeling Troubled and Troubling Youth: The Name Game

She's depressed.

That kid's got an attention deficit hyperactivity disorder.

He's learning disabled.

What's in a name? Strong images are associated with diagnostic labels, and people act upon these images. Sometimes the images are useful generalizations; sometimes they are harmful stereotypes. Sometimes they guide practitioners toward good ways to help; sometimes they contribute to "blaming the victim" -- making young people the focus of intervention rather than pursuing system deficiencies that are causing the problem in the first place. In all cases, diagnostic labels can profoundly shape a person's future.

Youngsters manifesting emotional upset, misbehavior, and learning problems commonly are assigned psychiatric labels that were created to categorize internal disorders. Thus, there is increasing use of terms such as anxiety disorder, phobia, ADHD, depression, and LD. This happens despite the fact that the problems of most youngsters are not rooted in internal pathology. Indeed, many of their troubling symptoms would not have developed if their environmental circumstances had been appropriately different.

Diagnosing Behavioral, Emotional, and Learning Problems

The thinking of those who study behavioral, emotional, and learning problems has long been dominated by models stressing *person* pathology. This is evident in discussions of cause, diagnosis, and intervention strategies. Because so much discussion focuses on person pathology, diagnostic systems have not been developed in ways that adequately account for psychosocial problems.

Many practitioners who use prevailing diagnostic labels understand that most problems in human functioning result from the interplay of person and environment. To counter nature *versus* nurture biases in thinking about problems, it helps to approach all diagnosis guided by a broad perspective of what determines human behavior.

A Broad View of Human Functioning

Before the 1920's, dominant thinking saw human behavior as determined primarily by person variables, especially inborn characteristics. As behaviorism gained in influence, a strong competing view arose. Behavior was seen as shaped by environmental influences, particularly the stimuli and reinforcers one encounters.

Today, human functioning is viewed in *transactional* terms -- as the product of a reciprocal interplay between person and environment (Bandura, 1978). However, prevailing approaches to labeling and addressing human problems still create the impression that problems are determined by *either* person or environment variables. This is both unfortunate and unnecessary -- unfortunate because such a view limits progress with respect to research and practice, unnecessary because a transactional view encompasses the position that problems may be caused by person, environment, or both. This broad paradigm encourages a comprehensive perspective of cause and correction.

Toward a Broad Framework

A broad framework offers a useful *starting* place for classifying behavioral, emotional, and learning problems in ways that avoid over-diagnosing internal pathology. Such problems can be differentiated along a continuum that separates those caused by internal factors, environmental variables, or a combination of both.

Problems caused by the environment are placed at one end of the continuum (referred to as Type I problems). At the other end are problems caused primarily by pathology within the person (Type III problems). In the middle are problems stemming from a relatively equal contribution of environ-mental and person sources (Type II problems).

Diagnostic labels meant to identify *extremely* dysfunctional problems *caused by pathological conditions within a person* are reserved for individuals who fit the Type III category.

At the other end of the continuum are individuals with problems arising from factors outside the person (i.e., Type I problems). Many people grow up in impoverished and hostile environmental circumstances. Such conditions should be considered first in hypothesizing what *initially* caused the individual's behavioral, emotional, and learning problems. (After environmental causes are ruled out, hypotheses about internal pathology become more viable.)

To provide a reference point in the middle of the continuum, a Type II category is used. This group consists of persons who do not function well in situations where their individual differences and minor vulnerabilities are poorly accommodated or are responded to hostilely. The problems of an individual in this group are a relatively equal product of person characteristics and failure of the environment to accommodate that individual.

There are, of course, variations along the continuum that do not precisely fit a category. That is, at each point between the extreme ends, environment-person transactions are the cause, but the degree to which each contributes to the problem varies. Toward the environment end of the continuum, environmental factors play a bigger role (represented as E<--->p). Toward the other end, person variables account for more of the problem (thus e<--->P).

Problems Categorized on a Continuum Using a Transactional View of the Primary Locus of Cause

Problems caused by factors in the environment (E)	Problems caused equally by environment and person	Problems caused by factors in the the person (P)
E (E<--->p)	E<--->P (e<--->P)	P
Type I problems	Type II problems	Type III problems
•caused primarily by environments and systems that are deficient and/or hostile	•caused primarily by a significant *mismatch* between individual differences and vulnerabilities and the nature of that person's environment (not by a person's pathology)	•caused primarily by person factors of a pathological nature
•problems are mild to moderately severe and narrow to moderately pervasive	•problems are mild to moderately severe andpervasive	•problems are moderate to profoundly severe and moderate to broadly pervasive

Clearly, a simple continuum cannot do justice to the complexities associated with labeling and differentiating psychopathology and psychosocial problems. However, the above conceptual scheme shows the value of starting with a broad model of cause. In particular, it helps counter the tendency to jump prematurely to the conclusion that a problem is caused by deficiencies or pathology within the individual and thus can help combat the trend toward blaming the victim (Ryan, 1971). It also helps highlight the notion that improving the way the environment accommodates individual differences may be a sufficient intervention strategy.

There is a substantial community-serving component in policies and procedures for classifying and labeling exceptional children and in the various kinds of institutional arrangements made to take care of them. "To take care of them" can and should be read with two meanings: to give children help and to exclude them from the community.

Nicholas Hobbs

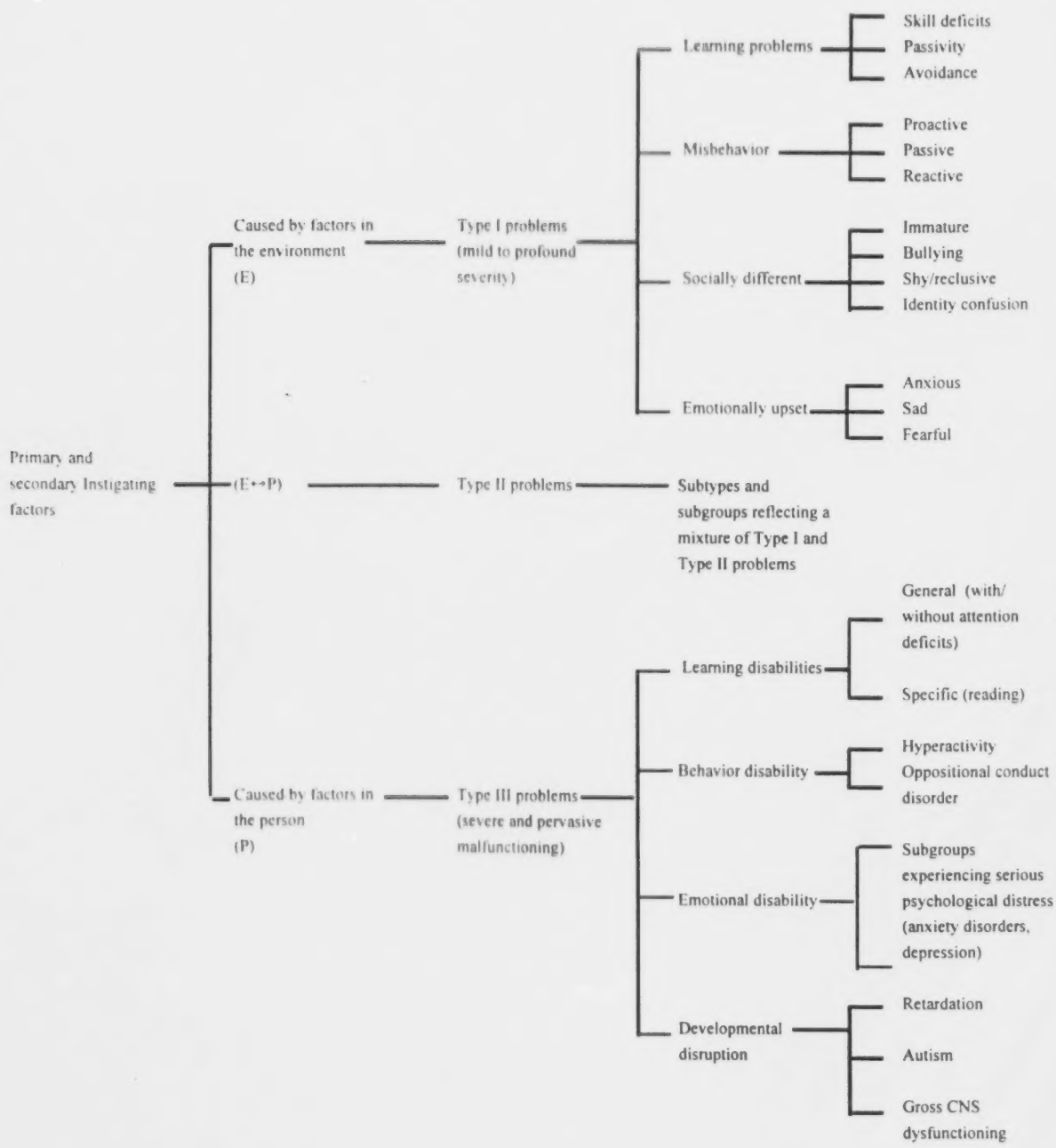
After the general groupings are identified, it becomes relevant to consider the value of differentiating subgroups or subtypes within each major type of problem. For example, subtypes for the Type III category might first differentiate behavioral, emotional, or learning problems arising from serious internal pathology (e.g., structural and functional malfunctioning within the person that causes disorders and disabilities and disrupts development). Then subtypes might be differentiated within each of these categories. For illustrative purposes: Figure 2 presents some ideas for subgrouping Type I and III problems.

References

Bandura, A. (1978). The self system in reciprocal determination. *American Psychologist, 33*, 344-358.

Ryan, W. (1971). *Blaming the victim.* New York: Random House.

Figure 2: Categorization of Type I, II, and III Problems



Source: H. S. Adelman and L. Taylor (1993). Learning problems and learning disabilities. Pacific Grove. Brooks/Cole. Reprinted with permission.

B. Environmental Situations and Potentially Stressful Events

The American Academy of Pediatrics has prepared a guide on mental health for primary care providers. The guide suggests that commonly occurring stressful events in a youngsters life can lead to common behavioral responses. Below are portions of Tables that give an overview of such events and responses.

Environmental Situations and Potentially Stressful Events Checklist

Challenges to Primary Support Group
- Challenges to Attachment Relationship
- Death of a Parent or Other Family Member
- Marital Discord
- Divorce
- Domestic Violence
- Other Family Relationship Problems
- Parent-Child Separation

Changes in Caregiving
- Foster Care/Adoption/Institutional Care
- Substance-Abusing Parents
- Physical Abuse
- Sexual Abuse
- Quality of Nurture Problem
- Neglect
- Mental Disorder of Parent
- Physical Illness of Parent
- Physical Illness of Sibling
- Mental or Behavioral disorder of Sibling

Other Functional Change in Family
- Addition of Sibling
- Change in Parental Caregiver

Community of Social Challenges
- Acculturation
- Social Discrimination and/or Family Isolation

Educational Challenges
- Illiteracy of Parent
- Inadequate School Facilities
- Discord with Peers/Teachers

Parent or Adolescent Occupational Challenges
- Unemployment
- Loss of Job
- Adverse Effect of Work Environment

Housing Challenges
- Homelessness
- Inadequate Housing
- Unsafe Neighborhood
- Dislocation

Economic Challenges
- Poverty
- Inadequate Financial Status

Legal System or Crime Problems

Other Environmental Situations
- Natural Disaster
- Witness of Violence

Health-Related Situations
- Chronic Health Conditions
- Acute Health Conditions

*Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care (1996). American Academy of Pediatrics.

Common Behavioral Responses to Environmental Situations and Potentially Stressful Events

INFANCY-TODDLERHOOD (0-2Y)
BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
- N/A

Emotions and Moods
- Change in crying
- Change in mood
- Sullen, withdrawn

Impulsive/Hyperactive or Inattentive Behaviors
- Increased activity

Negative/Antisocial Behaviors
- Aversive behaviors, i.e., temper tantrum, angry outburst

Feeding, Eating, Elimination Behaviors
- Change in eating
- Self-induced vomiting
- Nonspecific diarrhea, vomiting

Somatic and Sleep Behaviors
- Change in sleep

Developmental Competency
- Regression or delay in developmental attainments
- Inability to engage in or sustain play

Sexual Behaviors
- Arousal behaviors

Relationship Behaviors
- Extreme distress with separation
- Absence of distress with separation
- Indiscriminate social interactions
- Excessive clinging
- Gaze avoidance, hypervigilant gaze...

MIDDLE CHILDHOOD (6-12Y)
BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
- Transient physical complaints

Emotions and Moods
- Sadness
- Anxiety
- Changes in mood
- Preoccupation with stressful situations
- Self -destructive
- Fear of specific situations
- Decreased self-esteem

Impulsive/Hyperactive or Inattentive Behaviors
- Inattention
- High activity level
- Impulsivity

Negative/Antisocial Behaviors
- Aggression
- Noncompliant
- Negativistic

Feeding, Eating, Elimination Behaviors
- Change in eating
- Transient enuresis, encopresis

Somatic and Sleep Behaviors
- Change in sleep

Developmental Competency
- Decrease in academic performance

Sexual Behaviors
- Preoccupation with sexual issues

Relationship Behaviors
- Change in school activities
- Change in social interaction such as withdrawal
- Separation fear
- Fear of being alone

Substance Use/Abuse...

EARLY CHILDHOOD (3-5Y)
BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
- N/A

Emotions and Moods
- Generally sad
- Self-destructive behaviors

Impulsive/Hyperactive or Inattentive Behaviors
- Inattention
- High activity level

Negative/Antisocial Behaviors
- Tantrums
- Negativism
- Aggression
- Uncontrolled, noncompliant

Feeding, Eating, Elimination Behaviors
- Change in eating
- Fecal soiling
- Bedwetting

Somatic and Sleep Behaviors
- Change in sleep

Developmental Competency
- Regression or delay in developmental attainments

Sexual Behaviors
- Preoccupation with sexual issues

Relationship Behaviors
- Ambivalence toward independence
- Socially withdrawn, isolated
- Excessive clinging
- Separation fears
- Fear of being alone

ADOLESCENCE (13-21Y)
BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
- Transient physical complaints

Emotions and Moods
- Sadness
- Self-destructive
- Anxiety
- Preoccupation with stress
- Decreased self-esteem
- Change in mood

Impulsive/Hyperactive or Inattentive Behaviors
- Inattention
- Impulsivity
- High activity level

Negative/Antisocial Behaviors
- Aggression
- Antisocial behavior

Feeding, Eating, Elimination Behaviors
- Change in appetite
- Inadequate eating habits

Somatic and Sleep Behaviors
- Inadequate sleeping habits
- Oversleeping

Developmental Competency
- Decrease in academic achievement

Sexual Behaviors
- Preoccupation with sexual issues

Relationship Behaviors
- Change in school activities
- School absences
- Change in social interaction such as withdrawal

Substance Use/Abuse...

* Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care (1996). American Academy of Pediatrics

CARING FOR EVERY CHILD'S MENTAL HEALTH
communities together

FACT SHEET

Anxiety Disorders in Children and Adolescents

This is one of a series of fact sheets on the mental, emotional, and behavior disorders that can appear in childhood or adolescence. The Center for Mental Health Services extends appreciation to the National Institute of Mental Health for contributing to the preparation of this fact sheet. Any questions or comments about its contents may be directed to the CMHS National Mental Health Services Knowledge Exchange Network (KEN) — see contact information below.

What Are Anxiety Disorders?

Young people with an anxiety disorder typically are so afraid, worried, or uneasy that they cannot function normally. Anxiety disorders can be long-lasting and interfere greatly with a child's life. If not treated early, anxiety disorders can lead to:

- missed school days or an inability to finish school;
- impaired relations with peers;
- low self-esteem;
- alcohol or other drug use;
- problems adjusting to work situations; and
- anxiety disorder in adulthood.

In this fact sheet, "Mental Health Problems" for children and adolescents refers to the range of all diagnosable emotional, behavioral, and mental disorders. They include depression, attention-deficit/hyperactivity disorder, and anxiety, conduct, and eating disorders, among others. Mental health problems affect one in every five young people at any given time.

"Serious Emotional Disturbances" for children and adolescents refers to the above disorders when they severely disrupt daily functioning in home, school, or community. Serious emotional disturbances affect 1 in every 20 young people at any given time.

What Are the Signs of Anxiety Disorder?

There are a number of different anxiety disorders that affect children and adolescents. Several are described below.

Generalized Anxiety Disorder. Children and adolescents with this disorder experience extreme, unrealistic worry that does not seem to be related to any recent event. Typically, these young people are very self-conscious, feel tense, have a strong need for reassurance, and complain about stomach aches or other discomforts that don't appear to have any physical basis.

Phobias. A phobia is an unrealistic and excessive fear of some situation or object. Some phobias, called specific phobias, center on animals, storms, water, heights, or situations, such as being in an enclosed space. Children and adolescents with social phobias are terrified of being criticized or judged harshly by others. Because young people with phobias will try to avoid the objects and situations that they fear, the disorder can greatly restrict their lives.

Panic Disorder. Panic disorder is marked by repeated panic attacks without apparent cause. Panic attacks are periods of intense fear accompanied by pounding heartbeat, sweating, dizziness, nausea, or a feeling of imminent death. The experience is so scary that the young person lives in dread of another attack. He or she may go to great lengths to avoid any situation that seems likely to bring on a panic attack. A child with panic disorder may not want to go to school or be separated from his or her parents.

U.S. Department of Health and Human Services
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CARING FOR EVERY CHILD'S MENTAL HEALTH: Communities Together Campaign

For information about children's mental health, contact the CMHS Knowledge Exchange Network
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SAMHSA

Obsessive-Compulsive Disorder. A child with obsessive-compulsive disorder becomes trapped in a pattern of repetitive thoughts and behaviors. Even though the child may agree that the thoughts or behaviors appear senseless and distressing, the repetitions are very hard to stop. The compulsive behaviors may include repeated hand washing, counting, or arranging and rearranging objects.

Post-Traumatic Stress Disorder. Post-traumatic stress disorder can develop in children or adolescents after they experience a very stressful event. Such events may include physical or sexual abuse; being a victim of or witnessing violence; or being caught in a disaster, such as a bombing or hurricane. Young people with post-traumatic stress disorder experience the event again and again in strong memories, flashbacks, or troublesome thoughts. As a result, the young person may try to avoid anything associated with the trauma. They may also overreact when startled or have difficulty sleeping.

How Common Are Anxiety Disorders?

Anxiety disorders are among the most common mental, emotional, and behavior problems that occur during childhood and adolescence. As many as 1 in 10 young people may have an anxiety disorder.* Among adolescents, more girls than boys are affected. About half of the children and adolescents with anxiety disorders also have a second anxiety disorder or other mental or behavioral disorder, such as depression.

Who Is at Risk?

Researchers have found that a person's basic temperament may play a role in some childhood and adolescent anxiety disorders. For example, some young people tend to be very shy and restrained in unfamiliar situations. This may be a sign that the child or adolescent is at risk for developing an anxiety disorder.

Researchers also suggest watching for signs of anxiety disorders when children are between the ages of 6 and 8. At this age, children grow less afraid of the dark and imaginary creatures and more anxious about school performance and social relationships. High levels of anxiety in a child aged 6 to 8, therefore, may be a warning sign that the child may develop anxiety disorder later. A child's fears may change as a child ages, which complicates research.

Studies suggest that children or adolescents are more likely to have an anxiety disorder if their parents have anxiety disorders. However, the studies do not prove whether the disorders are caused by biology, environment, or both. More studies are needed to clarify whether or not anxiety disorders can be inherited. The Federal Government's National Institute of Mental Health, a part of the National Institutes of Health, is pursuing a wide range of studies on anxiety disorders in children, adolescents, and adults.*

What Help Is Available for a Young Person With an Anxiety Disorder?

Children and adolescents with anxiety disorders can benefit from a variety of treatments and services. After an accurate diagnosis, possible treatments include:

- cognitive-behavioral treatment (where young people learn to deal with fears by modifying the way they think and behave);
- other individual therapy;
- family therapy;
- parent training; and
- medication.

While cognitive-behavioral approaches are effective in treating some anxiety disorders, medications work well with others. Some anxiety disorders benefit from a combination of these treatments. In general, more studies are needed to find which treatments work best for the various types of anxiety disorders.

A child or adolescent in need of treatment or services and his or her family may need a plan of care based on the severity and duration of symptoms. Optimally, this plan is developed with the family, service providers, and a service coordinator, who is referred to as a case manager. Whenever possible, the child or adolescent is involved in decisions.

**This estimate provides only a rough gauge of the prevalence rates (number of existing cases in a defined time period) for these disorders. The National Institute of Mental Health is currently engaged in a nationwide study to determine with greater accuracy the prevalence of mental disorders among children and adolescents. This information is needed to increase understanding of mental health problems and to improve the treatments and services that help young people who are affected by these conditions.*

Tying together all the various supports and services in a plan of care for a particular child and family is commonly referred to as a "system of care." A system of care is designed to improve the child's ability to function in all areas of life—at home, at school, and in the community.

> In a "System of Care," local organizations work in teams—with families as critical partners—to provide a full range of services to children and adolescents with serious emotional disturbances. The team strives to meet the unique needs of each young person and his or her family in or near their home. These services should also address and respect the culture and ethnicity of the people they serve. (For more information on systems of care, call 1.800.789.2647.)

What Can Parents Do?

If parents or other caregivers notice repeated symptoms of an anxiety disorder in a child or adolescent, they should:

- Talk with the child's doctor. The doctor can help determine whether the symptoms are caused by an anxiety disorder or by some other condition. Then, if needed, the doctor can refer the family to a mental health professional.
- Look for a mental health professional who has training and experience:
  - working with children and adolescents;
  - using cognitive-behavioral or behavior therapy; and
  - prescribing medications for this disorder or, if appropriate, cooperating with a physician who prescribes medications.

The mental health professional should be willing to work closely with the parents as well as with the child or adolescent and his or her school.

- Get accurate information from libraries, hotlines, or other sources.
- Ask questions about treatments and services.
- Talk to other families in the community.
- Find family network organizations.

It is important for people who are not satisfied with the mental health care they are receiving to discuss their concerns with the provider, to ask for information, and/or to seek help from other sources.

Important Messages About Children's and Adolescents' Mental Health:

- Every child's mental health is important.
- Many children have mental health problems.
- These problems are real and painful and can be severe.
- Mental health problems can be recognized and treated.
- Caring families and communities working together can help.
- Information is available—for free publications, references, and referrals to local and national resources and organizations—call 1.800.789.2647; TTY 301.443.9006; http://www.mentalhealth.org/

5.30.96

II. The Broad Continuum of Anxiety Problems

A. Developmental Variations
B. Problems
C. Disorders

The American Academy of Pediatrics has produced a manual for primary care providers that gives guidelines for psychological behaviors that are within the range expected for the age of the child, problems that may disrupt functioning but are not sufficiently severe to warrant the diagnosis of a mental disorder, and disorders that do meet the criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (4th ed.) of the American Psychiatric Association (DSM-IV).

Just as the continuum of Type I, II, and III problems presented in Section 1A does, the pediatric manual provides a way to describe problems and plan interventions without prematurely deciding that internal pathology is causing the problems. The manual's descriptions are a useful way to introduce the range of concerns facing parents and school staff.

A. Developmental Variation Within the Range of Expected Behaviors for That Age Group

DEVELOPMENTAL VARIATION

Anxious Variation

Fears and worries are experienced that are appropriate for developmental age and do not affect normal development.

Transient anxious responses to stressful events occur in an otherwise healthy child and they do not affect normal development.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Normal fears of noises, heights, and loss of physical support are present at birth. Fear of separation from parent figures and fear of strangers are normal symptoms during the first years of life. The latter peaks at 8 to 9 months. Feeding or sleeping changes are possible in the first year. Transient developmental regressions occur after the first year. Scary dreams may occur.

Early childhood
By age 3 years, children can separate temporarily from a parent with minimal crying or clinging behaviors. Children described as shy or slow to warm up to others may be anxious in new situations. Specific fears of thunder, medical settings, and animals are present.

Middle Childhood
In middle childhood, a child with anxious symptoms may present with motor responses (trembling voice, nail biting, thumb sucking) or physiologic responses (headache, recurrent abdominal pain, unexplained limb pain, vomiting, breathlessness). Normally these should be transient and associated with appropriate stressors. Transient fears may occur after frightening events, such as a scary movie. These should be relieved easily with reassurance.

Adolescence
Adolescents may be shy, avoid usual pursuits, fear separation from friends, and be reluctant to engage in new experiences. Risk-taking behaviors, such as experimentation with drugs or impulsive sexual behavior, may be seen.

SPECIAL INFORMATION

Clinicians should attempt to identify any potential stressful events that may have precipitated the anxiety symptoms (...).

Difficulty falling asleep, frequent night awakenings, tantrums and aggressiveness, and excessive napping may reflect anxiety.

*Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care. (1996) American Academy of Pediatrics

Note: dots (...) indicate that the material has been abridged at that point or that the original text refers to another section of the resource that is not included in this guide.

B. Problems--Behaviors Serious Enough to Disrupt Functioning with Peers, at School, at Home, but Not Severe Enough to Meet Criteria of a Mental Disorder.*

PROBLEM

Anxiety Problem

An anxiety problem involves excessive worry or fearfulness that causes significant distress in the child. However, the behaviors are not sufficiently intense to qualify for an anxiety disorder or adjustment disorder with anxious mood.

*Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care. (1996) American Academy of Pediatrics

Note: dots (...) indicate that the material has been abridged at that point or that the original text refers to another section of the resource that is not included in this guide.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy and Early Childhood
In infancy and early childhood, anxiety problems usually present with a more prolonged distress at separation or as sleep and feeding difficulties including anxious clinging when not separating.

Middle Childhood
In middle childhood, anxiety may be manifest as sleep problems, fears of animals, natural disasters, and medical care, worries about being the center of attention, sleep-overs, class trips, and the future (see Sadness and Related Symptoms cluster). Anxiety may involve some somatic symptoms such as tachycardia, shortness of breath, sweating, choking, nausea, dryness, and chest pain (...). Environmental stress may be associated with regression (loss of developmental skills), social withdrawal, agitation/hyperactivity, or repetitive reenactment of a traumatic event through play. These symptoms should not be severe enough to warrant the diagnoses of a disorder and should resolve with the alleviation of the stressors.

Adolescence
In adolescence, anxiety may be manifest as sleep problems and fears of medical care and animals. Worries about class performance, participation in sports, and acceptance by peers may be present. Environmental stress may be associated with social withdrawal, boredom (see Sadness and Related Symptoms cluster), aggressiveness, or some risk-taking behavior (e.g., indiscriminate sexual behavior, drug use, or recklessness).

SPECIAL INFORMATION

Anxiety problems have a number of different clinical presentations including persistent worries about multiple areas in the child's life, excessive or unreasonable fear of a specific object or situation, fear of situations in which the child has to perform or be scrutinized by others, excessive worry about separation from parents, or anxiety following a significant, identifiable stressor.

Separation difficulties may be prolonged if inadvertently rewarded by parents and can result in a separation anxiety disorder.

Parental response to the child's distress or anxiety is a key factor in the assessment of anxiety problems. The extent of the child's anxiety may be difficult to assess and the primary care clinicians should err on the side of referral to a mental health clinician if there is uncertainty about the severity of the condition.

C. Disorders that Meet the Criteria of a Mental Disorder as Defined by the Diagnostic and Statistical Manual of the American Psychiatric Association (Edition 4, 1994)

DISORDER	COMMON DEVELOPMENTAL PRESENTATIONS

Generalized Anxiety Disorder

This disorder is characterized by at least 6 months of persistent and excessive anxiety and worry. Excessive and persistent worry occurs across a multitude of domains or situations, such as school work, sports, or social performance, and is associated with impaired functioning. The disorder is often associated with somatic and subjective/behavioral symptoms of anxiety (see Special Information).

(see DSM-IV Criteria...)

Social Phobia

This phobia involves a marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The person recognizes the fear is excessive or un-reasonable. Avoidance of the situation leads to impaired functioning.

(see DSM-IV Criteria ...)

Specific Phobia

Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation. Exposure to the phobic stimulus provokes an immediate anxiety response. In individuals under 18 years, the duration is at least 6 months. The anxiety associated with the object/situation is not better accounted for by another mental disorder.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics

Note: dots (...) indicate that the material has been abridged at that point or that the original text refers to another section of the resource that is not included in this guide.

Infancy
Rarely diagnosed in infancy. During the second year of life, fears and distress occurring in situations not ordinarily associated with expected anxiety that is not amenable to traditional soothing and has an irrational quality about it may suggest a disorder.

The fears are, for example, intense or phobic reactions to cartoons or clowns, or excessive fear concerning parts of the house (e.g., attic or basement).

Early Childhood
Rarely diagnosed in this age group. In children, these disorders may be expressed by crying, tantrums, freezing, or clinging, or staying close to a familiar person. Young children may appear excessively timid in unfamiliar social settings, shrink from contact with others, refuse to participate in group play, typically stay on the periphery of social activities, and attempt to remain close to familiar adults to the extent that family life is disrupted.

Middle Childhood and Adolescence
Symptoms in middle childhood and adolescence generally include the physiologic symptoms associated with anxiety (restlessness, sweating, tension) (...) and avoidance behaviors such as refusal to attend school and lack of participation in school, decline in classroom performance or social functions. In addition, an increase in worries and sleep disturbances are present.

SPECIAL INFORMATION

Generalized anxiety disorder has subsumed the *DSM-III-R* diagnosis of overanxious disorder.

Severe apprehension about performance may lead to refusal to attend school. This must be distinguished from other causes of refusal, including realistically aversive conditions at school (e.g., the child is threatened or harassed), learning disabilities (...), separation anxiety disorder (see below), truancy (the child is not anxious about performance or separation), and depression (see Sadness and Related Symptoms cluster). To make these diagnoses in children, there must be evidence of capacity for social relationships with adults. Because of the early onset and chronic course of the disorder, impairment in children tends to take the form of failure to achieve an expected level of functioning rather than a decline from optimal functioning. Children with generalized anxiety disorder may be overly conforming, perfectionists and unsure of themselves and tend to redo tasks because of being zealous in seeking approval and requiring excessive reassurance about their performance and other worries.

DISORDER	COMMON DEVELOPMENTAL PRESENTATIONS

Separation Anxiety Disorder

Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached.

(see DSM-IV Criteria ...)

Infancy
Not relevant at disorder level.

Early and Middle Childhood
When separated from attachment figures, children may exhibit social withdrawal, apathy, sadness, difficulty concentrating on work or play. They may have fears of animals, monsters, the dark, muggers, kidnappers, burglars, car accidents; concerns about death and dying are common. When alone, young children may report unusual perceptual experiences (e.g., seeing people peering into their room).

Adolescence
Adolescents with this disorder may deny feeling anxiety about separation; however, it may be reflected in their limited independent activity and reluctance to leave home.

Panic Disorder

This disorder involves recurrent unexpected (uncued) panic attacks. Apprehension and anxiety about the attacks or a significant change in behavior related to the attack persists for at least 1 month. A panic attack is a discrete episode of intense fear or discomfort with sudden onset combining the following psychological symptoms— a sense of impending doom, fear of going crazy, and feelings of unreality—with somatic symptoms such as shortness of breath/dyspnea, palpitations/tachycardia, sweating, choking, chest pain, nausea, dizziness, paresthesia.

(see *DSM IV Criteria ...*)

Infancy
Not relevant at disorder level.

Early Childhood
In children, these disorders may be expressed by crying, tantrums freezing, clinging, or staying close to a familiar person during a panic attack.

Middle Childhood
Panic attacks may be manifested by symptoms such as tachycardia shortness of breath, spreading chest pain, and extreme tension.

Adolescence
The symptoms are similar to those seen in an adult, such as the sense of impending doom, fear of going crazy, feelings of unreality and somatic symptoms such as shortness of breath, palpitations, sweating, choking, and chest pain.

SPECIAL INFORMATION

Separation anxiety disorder must be beyond what is expected for the child's developmental level to be coded as a disorder. In infancy, consider a developmental variation or anxiety problem rather than separation anxiety disorder. Worry about separation may take the form of worry about the health and safety of self or parents.

Separation anxiety disorder may begin as early as preschool age and may occur at any time before age 18 years, but onset as late as adolescence is uncommon. Use early onset specifier if the onset of disorder is before 6 years. Children with separation anxiety disorder are often described as demanding, intrusive, and in need of constant attention which may lead to parental frustration.

Separation anxiety disorder is a common cause of refusal to attend school. Parental difficulty in separating from the child may contribute to the clinical problem (...). A break down in the marital relationship (marital discord) and one parent's over-involvement with the child is often seen (...). Children with serious current or past medical problems (...) may be overprotected by parents and at greater risk for separation anxiety disorder. Parental illness and death may also increase risk.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics

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SPECIAL INFORMATION, CONTINUED

Although panic attacks can be overwhelming, the social impairment in panic disorders is the result of secondary avoidance, rather than the attacks themselves. Panic attacks or panic symptoms can occur in a variety of anxiety problems or disorders, including specific phobia, social phobia, separation anxiety disorder, and posttraumatic stress disorder. Panic attacks in these disorders, however, are situationally bound, or cued; that is, they are triggered by specific contexts or environmental stimuli. Unexpected or uncued panic attacks must occur for a diagnosis of panic disorder. Major depressive disorder frequently (50% to 65%) occurs in individuals with panic disorder.

DISORDER

Posttraumatic Stress Disorder (PTSD)

PTSD occurs following exposure to an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. The child or adolescent has symptoms in each of the following three areas for more than 1 month, causing significant distress or impairment of functioning: (1) persistent reexperiencing of the trauma, (2) avoidance of stimuli associated with the trauma and diminished general responsiveness, and (3) increased arousal or hyper vigilance. In infancy, a numbing of responsiveness may also occur.

(see DSM-IV Criteria ...)

Acute Stress Disorder

(see *DSM-IV* Criteria ...)

* Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics.

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COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Rarely diagnosed but may take the form of extra fears or aggressive behaviors in response to stress.

Early Childhood, Middle Childhood, Adolescence
In children, distressing dreams of the event may, within several weeks, change into generalized nightmares of monsters, of rescuing others, or of threats to self or others. Reliving of the trauma rnay occur through repetitive play. Children may also exhibit various physical symptoms, such as stomachaches and headaches.

SPECIAL INFORMATION

PTSD follows exposure to acute or chronic stressors that involve actual or threatened death or serious injury to the child or others. The child must have reacted with intense fear, disorganized or agitated behavior, or helplessness. Stressors may be acute or chronic, single or multiple.

PTSD may be chronic and associated with significant morbidity. Symptoms of repetitive trauma re-enacting play and a sense of a foreshortened future may persist after distress is no longer present.

PTSD must be distinguished from normal bereavement. Bereavement is characterized by sadness and recurrent thoughts, but not by persistent impairment of functioning (see Sadness and Related Symptoms cluster).

Consider sexual abuse/rape (...). Because it may be difficult for children to report diminished interest in significant activities and constriction of affect, these symptoms should be carefully evaluated with reports from parents and teachers. In children, the sense of a foreshortened future may be evidenced by the belief that life will be too short to include becoming an adult.

DISORDER

Obsessive-Compulsive Disorder

The obsessions and/or compulsions interfere with functioning, cause marked distress, or occupy more than 1 hour a day.

(see DSM-IV Criteria...)

Anxiety Disorder, Not otherwise Specified

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Rarely presents at this age.

Early Childhood
The child evidences a higher degree of compulsive and ritualistic behavior, from holding onto certain objects, watching certain videotapes, or lining up toys in certain sequences. These rigidities are less responsive to soothing and interaction than at the problem level. When these ritualistic behaviors are associated with problems in relating and communicating (see Social Interaction Behaviors cluster).

Middle Childhood and Adolescence

The child presents with obsessions and compulsions such as repetitive hand washing, ordering, checking, counting, repeating words silently, repetitive praying. The obsessions or compulsions interfere with listening or attending in class and frequently grades worsen because the child cannot sit still during tests or lectures.

The child may fear harming himself or herself or others if compulsion is not performed and has problems with task completion.

SPECIAL INFORMATION

The child may be reluctant to talk about the condition; parental report may be the only reliable history. Sexuality may be the underlying concern in certain cases (...).

Children are more prone to engage in rituals at home than in front of peers, teachers, or strangers.

Although obsessive-compulsive disorder usually presents in adolescence or early adulthood, it may begin in childhood. For the most part onset is gradual, but acute onset has been noted in some cases.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care* (1996) American Academy of Pediatrics

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Adjustment Disorders

Diagnostic Features

The essential feature of an **Adjustment Disorder** is the development of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor or stressors. The symptoms must develop within 3 months after the onset of the stressor(s) (Criterion A). The clinical significance of the reaction is indicated either by marked distress that is in excess of what would be expected given the nature of the stressor, or by significant impairment in social or occupational (academic) functioning (Criterion B). This category should not be used if the disturbance meets the criteria for another specific Axis I disorder (e.g., a specific Anxiety or Mood Disorder) or is merely an exacerbation of a preexisting Axis I or II disorder (Criterion C). However, an Adjustment Disorder may be diagnosed in the presence of another Axis I or Axis II disorder if the latter does not account for the pattern of symptoms that have occurred in response to the stressor. The diagnosis of an Adjustment Disorder also does not apply when the symptoms represent Bereavement (Criterion D). By definition, an Adjustment Disorder must resolve within 6 months of the termination of the stressor (or its consequences) (Criterion E). However, the symptoms may persist for a prolonged period (i.e., longer than 6 months) if they occur in response to a chronic stressor (e.g., a chronic, disabling general medical condition) or to a stressor that has enduring consequences (e.g., the financial and emotional difficulties resulting from a divorce).

The stressor may be a single event (e.g., termination of a romantic relationship), or there may be multiple stressors (e.g., marked business difficulties and marital problems). Stressors may be recurrent (e.g., associated with seasonal business crises) or continuous (e.g., living in a crime-ridden neighborhood). Stressors may affect a single individual, an entire family, or a larger group or community (e.g., as in a natural disaster). Some stressors may accompany specific developmental events (e.g., going to school, leaving the parental home, getting married, becoming a parent, failing to attain occupational goals, retirement).

Subtypes and Specifiers

Adjustment Disorders are coded according to the subtype that best characterizes the predominant symptoms:

309.24 With Anxiety. This subtype should be used when the predominant manifestations are symptoms such as nervousness, worry, or jitteriness or, in children, fears of separation from major attachment figures.
309.28 With Mixed Anxiety and Depressed Mood. This subtype should be used when the predominant manifestation is a combination of depression and anxiety.

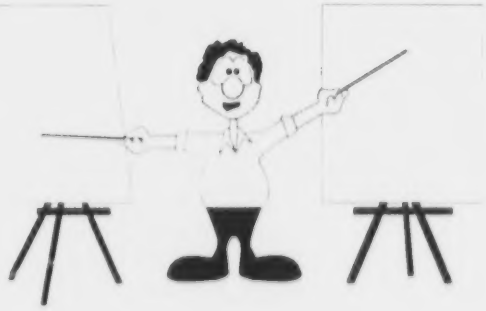
The duration of the symptoms of an Adjustment Disorder can be indicated by choosing one of the following specifiers:

Acute. This specifier can be used to indicate persistence of symptoms for less than 6 months.
Chronic. This specifier can be used to indicate persistence of symptoms for 6 months or longer. By definition, symptoms cannot persist for more than 6 months after the termination of the stressor or its consequences. The Chronic specifier therefore applies when the duration of the disturbance is longer than 6 months in response to a chronic stressor or to a stressor that has enduring consequences.

Excerpt from DSM IV, 1994

American Psychiatric Association. (*1994*). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

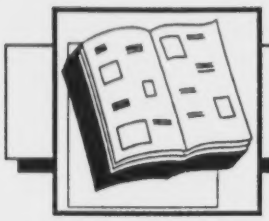
III. A Quick Overview of Some Basic Resources



A. A Few References and Other Sources of Information

B. Agencies and Online Resources Relevant to Anxiety-Related Problems and Disorders

C. Anxiety Problems: Consultation Cadre Contacts



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Books for Children and Teens

The Adolescent Health Center (1985). *A Guide To Managing Stress.* Adolescent Health Center, G-2186 W. Carpenter Road, Flint, MI 48505; Phone: (313) 789-1548.
Robinson, E.H., Rotter, J.C., Fey, M.A., Vogel, K.R. Helping Children Cope with Fears and Stress (1992). Source: ERIC Counseling and Student Services Clearinghouse, School of Education, 101 Park Building, University of North Carolina at Greensboro, North Carolina 27412-5001.

Books for Parents

The Adolescent Health Center (1988). *What you should know about stress and your child.* Adolescent Health Center, G-2186 W. Carpenter Road, Flint, MI 48505; Phone: (313) 789-1548
Foster, C.H. Polly's Magic Games: A Child's View of Obsessive-Compulsive Disorder. Ellsworth, ME: Dilligaf Publishing, 1994.
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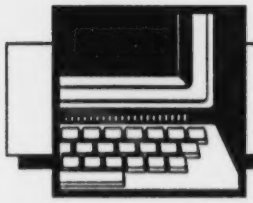
Videotape

The Touching Tree. Jim Callner, writer/director, Awareness films. Distributed by the O.C.D. Foundation, Inc., Milford, CT. (About a child with OCD)



B. Agencies and Online Resources Related to Anxiety Problems and Disorders

Access KEN (Center for Mental Health Services Knowledge Exchange Network)

Provides information about mental health via toll-free telephone services, an electronic bulletin board, and publications. KEN was developed for users of mental health services and their families, the general public, policy makers, providers, and the media. KEN is a national, one-stop source of information and resources on prevention, treatment, and rehabilitation services for mental illness.

Contact: P.O. Box 42490, Washington, DC 20015
Phone: 1-800-789-CMHS (2647) Monday to Friday, 8:30 A.M. to 5:00 P.M., EST
Electronic Bulletin Board System (BBS): 1-800-790-CMHS (2647)
Telecommunications Device for the Deaf (TDD): 301-443-9006; Fax: 301-984-8796
E-mail: kengmentalhealth.org Website: http://www.mentalhealth.org/

Agoraphobics Building Independent Lives (ABIL, Inc)

National group offers mutual support, encouragement, hope, goal setting and education for persons with agoraphobia, anxiety or panic-related disorders and their families and friends.

Contact: 3805 Cutshaw Ave., Suite 415, Richmond, VA 23230. Phone: (804)353-3964; Fax: (804)353-3687. E-mail: abil1996@aol.com

Agoraphobics In Motion (AIM)

Self-help groups that use specific behavioral and cognitive techniques to help people recover from agoraphobia, anxiety, and panic attacks. Relaxation techniques and small group discussions, field trips.

Contacts: 1719 Crooks, Royal Oak, MI 48067-1306. Phone: (248)547-0400

Anxiety Disorders Association of America

Promotes the prevention and cure of anxiety disorders and works to improve the lives of all people who suffer from them. ADDA is made up of professionals who conduct research and treat anxiety disorders and individuals who have a personal or general interest in learning more about such disorders. The website provides access to the latest books, tapes, journal articles and to listings of self-help/support groups and experienced treatment providers in your area.

Contact: 11900 Parklawn Drive, Suite 100, Rockville, MD 20852, USA
http://www.adaa.org/

Anxiety Network International

The Anxiety Network is an international outreach to educate and inform the general public about the anxiety disorders, and to educate and support people with anxiety disorders. The website provides information, support, and therapy for the most prevalent anxiety disorders: social anxiety (social phobia), panic/agoraphobia, and generalized anxiety.

Contact: Dr. Thomas Richards, 4643 East Thomas, Suite 6, Phoenix, AZ, 85018-7740, Phone: (602) 952-9846, E-mail: ascaz@CONCENTRIC.NET, http://www.anxietynetwork.com

Awareness Foundation for OCD and Related Disorders

This foundation combines the expertise and experience of dynamic workshop speakers with the emotional impact of film to increase professional, educational, and public understanding of Obsessive-Compulsive Disorder and related disorders.

Contact: 15559 Union Ave., Box 130, Los Gatos, CA 95032-3904
Phone/Fax (408)559-7971; e-mail: Awareness9@aol.com
http://www.ocdawareness.com

Connect for Kids

A virtual encyclopedia of information for adults who want to make their communities better places for kids. Through radio, print, and TV ads, a weekly E-mail newsletter and a discussion forum, this project provides the tools to help people become more active citizens—from volunteering to voting—on behalf of kids. Kids Campaigns provides information on legislation pertaining to children and families, and on how to encourage candidate accountability on behalf of children and families.

Contact: Benton Foundation, 1634 Eye Street, NW, 11th Floor, Washington, DC 20006; Phone: (202) 638-5770; Fax: (202) 638-5771; E-mail: kidscampaign@benton.org; http://www.connectforkids.org

Center for Anxiety and Stress Treatment

The site contains on-line articles, self-help book, audio-tape based anxiety reduction program, group manual, and workshops. Mission is to provide resources which can help consumers manage and regain their lives.

Contact: Stress Release Health Enterprises, Shirley Babior, LCSW, Center for Anxiety and Stress Treatment, 4225 Executive Square, Suite 1110, La Jolla, CA 92037, Phone: (619) 542-0536, fax: (619) 542-0730, E-mail: health@stressrelease.com http://www.stressrelease.com/

Council on Anxiety Disorders: Model Group

2 local affiliated groups in GA. Meetings provide education, support and encouragement for people with anxiety disorders. Packets available that include personal stories, resource list of places to contact and information about treatment. (Model groups are not international groups. Contact this group only if you are interested in starting a similar group in your area).

Contact: Route 1, Box 1364, Clarkesville, GA 30523.
Phone (706)947-3854; Fax: (706)947-1265; E-mail: slvau@stc.net

Mental Health Net (MHN)

A comprehensive, fun, and useful guide to every mental health topic imaginable, with over 3,000 individual resources listed. The information found here is for everyone associated with mental health. Topics covered on MHN range from disorders such as depression, anxiety, and substance abuse, to professional journals and self-help magazines that are available online.

Contact: 570 Metro Place North, Dublin, OH 43017;
Tel. 614-764-0143; Fax 614-764-0362; http://mentalhelp.net

National Anxiety Foundation

A volunteer non-profit entity that aims to educate the public and professionals about anxiety through printed and electronic media.

Contact: 3135 Custer Drive, Lexington, KY 40517- 4001
Phone: (606) 272-7166; http://www.lexington-on-line.com/naf.html

National Institute of Mental Health (NIMH)

Conducts and supports research nationwide on mental illness and mental health, including studies of the brain, behavior, and mental health services. NIMH is a part of the National Institutes of Health (NIH), the principal biomedical and behavioral research agency of the United States Government. NIH is a component of the U.S. Department of Health and Human Services.

NIMH Public Inquiries, 5600 Fishers Lane, Room 7C-02, MSC 8030, Bethesda, MD 20892-8030; http://www.nimh.nih.gov

National Mental Health Consumers' Self-Help Clearinghouse

This consumer-run national technical assistance center promotes consumer/survivor participation in planning, providing, and evaluating mental health and community support services. It provides technical assistance and information to consumers/providers interested in developing self-help services and advocating to make traditional services more consumer oriented.

Contact: 1211 Chestnut Street, Philadelphia, PA 19107 Phone: (800) 553-4539

NIMH Anxiety Disorders Education Program

A national education campaign developed by the National Institute of Mental Health (NIMH) to increase awareness among the public and health care professionals that anxiety disorders are real medical illnesses that can be effectively diagnosed and treated. It seeks to counter widespread lack of understanding and stigma that prevents many people from being diagnosed and receiving treatments that have been proven effective.

Contact: 5600 Fishers Lane, Room 7C-02, MSC 8030, Bethesda, MD 20892-8030
NIMH Panic Information Line: 1-800-64-Panic, NIMH Toll-free Information Services: 1-88-88-ANXIETY, http://www.nimh.nih.gov/anxiety/

Obsessive-Compulsive Foundation, Inc.

An international not-for-profit organization composed of people with obsessive compulsive disorder (OCD) and related disorders, their families, friends, professionals and other concerned individuals. The mission is to educate the public and professional communities about OCD; to provide assistance to individuals with OCD; and to support research into the causes and effective treatments of OCD and related disorders.

Contact: P.O. Box 70, Milford, CT 06460-0070, Phone: (203) 878-5669
Fax: (203)874-282; E-mail: info@ocfoundation.org; http://www.ocfoundation.org

The OCD Resource Center of South Florida

Disseminates information about new developments in the treatment of obsessive-compulsive disorder (OCD). Estimates that more than three to five million adults and 500,000 children nationwide suffer from this seriously disabling disorder. The website describes available services for children and adults including assessment and evaluation, medication, individual cognitive-behavior therapy, group and family therapy.

Contact: 3475 Sheridan Street, Suite 310, Hollywood, Florida 33021
Phone: (954) 962-6662, Fax: (954) 962-6164, http://www.ocdhope.com

Open Doors Institute

Based on techniques developed by Dr. Lynne Freeman, this organization provides cognitive-behavioral therapy, psychiatric evaluation, phone sessions, and an available network of providers.

Contact: 13601 Ventura Blvd., Suite 600, Sherman, Oaks, California 91423
Phone: 818-710-6442; E-mail: info@opendoorsinstitute.com
www.opendoorsinstitute.com/serv03.htm

Recovery, Inc.

An international community mental health organization that offers a self-help method of will training; a system of techniques for controlling temperamental behavior and changing attitudes toward nervous symptoms, anxiety, depression, anger and fears.

Contact: 802 N. Dearborn St. Chicago, IL 60610. Phone: (312)337-5661; Fax: (312)337-5756; E-mail: spot@recovery-inc.com; http://www.recovery-inc.com

Ross Center for Anxiety and Related Disorders, Inc.

A nationally-known comprehensive, outpatient facility in Washington, DC, which offers state-of-the-art treatment for anxiety disorders. Offers an accelerated, flexible Intensive Treatment Program ideal for individuals living in other parts of the country who wish to be treated at the center.

Contact: 4545 42nd Street, N.W., Suite 311, Washington, D.C. 20016
Phone: 202-363-1010 http://www.rosscenter.com

C. Anxiety Problems:
Consultation Cadre Contacts

Professionals across the country volunteer to network with others to share what they know. Some cadre members run programs, many work directly with youngsters in a variety of settings and focus on a wide range of psychosocial problems. Others are readyto share their expertise on policy, funding, and major system concerns. The group encompasses professionals working in schools, agencies, community organizations, resource centers, clinics and health centers, teaching hospitals, universities, and so forth.

People ask how we screen cadre members. We don't! It's not our role to endorse anyone. We think it's wonderful that so many professionals want to help their colleagues, and our role is to facilitate the networking. If you are willing to offer informal consultation at no charge to colleagues trying to improve systems, programs, and services for addressing barriers to learning, let us know. Our list is growing each day; the following are those currently on file related to this topic. Note: the list is alphabetized by Region and State as an aid in finding a nearby resource.

Updated 8/15/01

Central States

Louisiana
Raymond Morley
Consultant
Education Services for Children, Family, & Community
Iowa Department of Education
Grimes State Office Building
Des Moines, IA 50319-0146
Phone: 515/281-3966
Email: rmorley@max.state.ia.us

Minnesota
Gordon Wrobel
Health Care Coordinator
National Association of School Psychologists
1500 Highway 36 West
Roseville, MN 55113-4266
Phone: 612/297-1641
Fax: 612/297-7368
Email: gordywrobel@covelodge.com

Ohio
Joseph E. Zins
Professor
University of Cincinnati
339 Teachers College
Cincinnati, OH 45221-0002
Phone: 513/556-3341
Fax: 513/556-1581
Email: joseph.zins@uc.edu

East

District of Colombia
Joan Dodge
Senior Policy Associate
Georgetown University - Child Development Center
Nat'l Tech. Assistance Ctr for Children's Mental Hlth
3307 M Street, NW, Suite 401
Washington, DC 20007-3935
Phone: 202/687-5054
Fax: 202/687-1954
Email: dodgej@gunet.georgetown.edu

Delaware
Deanna Mears Pandya
Mental Health Counselor
VNA Wellness Center
1901 S. College Avenue
Newark, DE 19702
Phone: 302/369-1501
Fax: 302/369-1503

Kathy Spencer
Social Worker
Dover High School Wellness Center -VNA
1 Patrick Lynn Drive
Dover, DE 19901
Phone: 302/672-1586
Fax: 302/674-2065

East (contd.)

Maryland

Lawrence Dolan
Principal Research Scientist
Center for Res. on the Education of Students Placed at Risk
Johns Hopkins University
3505 N. Charles Street
Baltimore, MD 21218
Phone: 410/516-8809
Fax: 410/516-8890
Email: larryd@jhunix.hcf.jhu.edu

William Strein
Associate Professor
University of Maryland
3212 Benjamin Building
1125 College Park
College Park, MD 20742
Phone: 301/405-2869
Fax: 301/405-9995
Email: strein@umail.umd.edu

Maine

Michel Lahti
Project Coordinator
School-Linked Mental Health Services Project
Institute for Public Sector Innovation - U of Southern Maine
295 Water Street, 2nd floor
Augusta, ME 04330
Phone: 207/626-5274
Fax: 207/626-5210
Email: michel.lahti@state.me.us

Rhode Island

Robert Wooler
Executive Director
RI Youth Guidance Center, Inc.
82 Pond Street
Pawtucket, RI 02860
Phone: 401/725-0450
Fax: 401/725-0452

Northwest

Oregon

Philip Bowser
School Psychologist
Roseburg Public Schools
1419 Valley View Drive, NW
Roseburg, OR 97470
Phone: 503/440-4038
Fax: 503/440-4003
Email: pbowser@roseburg.k12.or.us

Utah

Margaret Rose
Health Education Specialist
Utah State Office of Education
250 East 500 Street
Salt Lake City, UT 84111
Phone: 801/538-7864
Fax: 801/538-7769
Email: mrose@usoe.k12.ut.us

Southeast

Arkansas

Barbara Baldwin
Social Worker
Arkansas Department of Health
Central High Wellness Clinic
1500 S. Park
Little Rock, AR 72202
Phone: 501/324-2330
Fax: 501/374-7920
Email: cassanb@aol.com

Maureen Bradshaw
State Coordinator, for Behavioral Interventions
Arch Ford Education Service Cooperative
101 Bulldog Drive
Plummerville, AR 72117
Phone: 501/354-2269
Fax: 501/354-0167
Email: mbradshaw@conwaycorp.net

Florida

Howard M. Knoff
Professor
School Psychology Program/Institute for School Reform
University of South Florida
4202 East Fowler Avenue, EDU 162
Tampa, FL 33620-7750
Phone: 813/974-9498
Fax: 813/974-5814
Email: knoff@tempest.coedu.usf.edu
Phone: 813/974-9498
Fax: 813/974-5814
Email: knoff@tempest.coedu.usf.edu

Southeast (contd.)

Georgia

Ronda Talley
Executive Director and Professor
Rosalynn Carter Institute for Human Development
Georgia Southwestern State University
800 Wheatley St.
Americus, GA 31709
Phone: 912/928-1234
Fax: 912/931-2663
Email: rtalley@canes.gsw.edu

Kentucky

Daniel Clemons
Coordinator
Fairdale Youth Service Center
1001 Fairdale Road
Fairdale, KY 40118
Phone: 502/485-8866
Fax: 502/485-8761

William Pfohl
Professor of Psychology
Western Kentucky University
Psychology Department
1 Big Red Way
Bowling Green, KY 42101
Phone: 270/745-4419
Fax: 270/745-6474
Email: william.pfohl@wku.edu

Louisiana

Dean Frost
Director, Bureau of Student Services
Louisiana State Department of Education
P.O. Box 94064
Baton Rouge, LA 70804
Phone: 504/342-3480
Fax: 504/342-6887

North Carolina

Bill Hussey
Section Chief
Dept. of Public Instruction
301 N. Wilmington St.
Raleigh, NC 27601-2825
Phone: 919/715-1576
Fax: 919/715-1569
Email: bhussy@dpi.state.nc.us

Steven Pfeiffer
Director and Research Professor
Duke University/ Talent Identification Program
1121 West Main Street Suite 100
Durham, NC 27701
Phone: 919/683-1400
Fax: 919/683-1742
Email: pfeiffer@tip.duke.edu

William Trant
Director Exceptional Programs
New Hanover County Schools
1802 South 15th Street
Wilmington, NC 28401
Phone: 910/254-4445
Fax: 910/254/4446
Email: wtrant@wilmington.net

Virginina

Dianne Dulicai
Ph.D., ADTR,Co-chair
National Alliance of Pupil Services Organization
7700 Willowbrook Rd.
Fairfax Station, VA 22039
Phone: 703/250-3414
Fax: 703/250-6324
Email: dianne.dulicai@gte.net

Southwest

California

Marcia London Albert
7900 Loyola Blvd.
Los Angeles, CA 90045-8208
Phone: 310/338-2847
Fax: 310/338-7657
Email: malbert@lmumail.lmu.edu

Jackie Allen
Professor
Allen Consulting Associates
705 Montana Vista Ct.
Fremont, CA 94539
Phone: 510/656-6857
Fax: 510/656-6880
Email: jallen20@ix.netcom.com

Kelly Corey
Regional Director of Business Dev.
Provo Canyon School
P.O. Box 892292
Temecula, CA 92589-2292
Phone: 909/694-9462
Fax: 909/694-9472

Sylvia Dean
Coordinator of Psychological Service
Los Angeles School District
11380 W. Graham Place - Bldg. Y
Los Angeles, CA 90064
Phone: 310/444-9913
Fax: 310/497-5722

California (contd.)

Randall Hansen
Licensed Educational Psychologist
Family Medical Care
110 North Spring Street
Blythe, CA 92225
Phone: 760/921-3167
Fax: 760/921-3167
Email: rhansen@telis.org

Janice Jetton
Pediatric/Adolescent Nurse Practitioner
Kaiser Permanente, Orange County
Coordinator/Huntington Beach Union High SD
1982 Port Locksleigh Place
Newport Beach, CA 92660
Phone: 949/640-1977
Fax: 949/640-0848
Email: JanJetton@aol.com

Kelly Corey
Regional Director of Business Dev.
Provo Canyon School
P.O. Box 892292
Temecula, CA 92589-2292
Phone: 909/694-9462
Fax: 909/694-9472

Danielle Kelley
Psychiatric Social Worker
Roosevelt Elementary School
700 North Bradfield Avenue
Compton, CA 90021
Phone: 310/898-6350
Fax: 310/632-0338

Ernest Lotecka
Director
APAL Foundation
7510 Brava Street
Carlsbad, CA 92009-7503
Phone: 760/599-5366
Email: ell@worldnet.att.net

Marian Schiff
School Psychologist
LAUSD Montague St. School
13000 Montague St.
Pacoima, CA 91331
Phone: 818/899-0215

Susan Sheldon
School Psychologist
Los Angeles Unified School District
5423 Monte Vista St.
Los Angeles, CA 90042
Phone: 213/254-7262
Fax: 213/259-9757

Howard Taras
District Physician
San Diego City Schools
2351 Cardinal Lane, Annex B
San Diego, CA 92123
Phone: 858/627-7595
Fax: 858/627-7444
Email: htaras@ucsd.edu

Don Leton
Psychologist
Honolulu Schools
Special Services
4967 Kilauea Av.
Honolulu, HI 96816
Phone: 808/733-4940
Fax: 808/733-4944
Email: leton@hula.net

Concerned about Pscyhosocial Problems?
Child and Adolescent Mental Health?
Need Technical Assistance?
Resource Materials?

Mental Health in Schools Center
Training and Technical Assistance

We can Help!!!!

CONTACT US:

Center for Mental Health in Schools
P.O. Box 951563
Los Angeles, CA 90095-1563
Phone: (310) 825-3634
Fax: (310) 206-8716
E-mail: smhp@ucla.edu

--- *or* ---

use our Website to access Center Resources!!!!!

http://smhp.psych.ucla.edu
If we don't have it, we can tell you where to get it!!!

- Request our free Quarterly Newsletter
- Sign-up for our monthly ENEWS
- Get Technical Assistance
- Try our Continuing Education Modules
- Ask about our guidebooks and manuals
- Search our clearinghouse
- Download materials
- Gateway to other relevant sites
- Keep up - to- date on resources and events

..and much, much more!!!!

We keep adding to and improving the center --- so keep in contact.

IV. Interventions for Anxiety Problems

A. Accommodations to Reduce Anxiety Problems
- ➤Anxiety Problems at a New School
- ➤Affect and Mood Problems: Children and Anxiety

B. Behavior Management and Self Instruction
- ➤Managing Traumatic Stress
- ➤Helping Children Cope with Fears and Stress

C. Empirically Supported Treatments for Anxiety Problems
- ➤Children with Phobic and Anxiety Disorders
- ➤Mastery of Your Anxiety and Panic

D. Medications Used to Treat Anxiety Problems

E. School Avoidance: Reactive and Proactive

Accommodations to Reduce Anxiety Problems at a New School

The following is excerpted from an article entitled "Changing Schools is Now the Norm, But Anxiety Problems are Not, Says UMASS Child Psychologist" that was published as a University of Massachusetts Medical Center news brief.

WORCESTER, Mass. (May 1, 1996) - Childhood anxiety is being diagnosed at an increasing rate nationally, and child health experts are still identifying anxiety disorders that were unknown as little as five to 10 years ago. Among the causes for anxiety in children lies the fear and discomfort of changing schools. According to Martin H. Young, PhD, associate professor of pediatrics at the University of Massachusetts Medical Center in Worcester, it's not uncommon for a youngster to have changed schools four times before even entering high school. "Changing schools is no longer the exception, it's the rule," says Dr. Young. "Not only from one town or state to the next, but there's also a tremendous number of children who regularly change schools within a single district."

While many children will adapt easily to a new school environment, others may be more vulnerable to anxiety due to pre-existing factors, notes the specialist in pediatric anxiety disorders. "Transferring to a new school can be a problem for a child who, for example, gets upset when separated from his parents," says Young, adding that separation anxiety can sometimes extend past the normal pre-school age years.

Stress in a child's life can also impair a smooth transition to a new school, says Young. "When people are stressed, they have a more difficult time making changes. There's a feeling among child professionals that kids now live in a much more stressful world than existed 10 to 15 years ago," notes Young. "The worry a child feels when a parent is laid-off or a family member is sick can affect his comfort in leaving home."

Children with chronic medical problems, Attention Deficit Hyperactivity Disorder or learning disabilities, may also need special help with adjusting to a new school. "These kids tend to have greater problems during even natural transitions than do children without special needs," says the UMass child psychologist.

In general, the older children are, the better they'll adapt to a new school. However, even adolescents can have a difficult time with transition, especially when they fear rejection by their new peers.

➤What are some of the classic signs that your child is not adjusting well to his new school?

Child is exhibiting "school avoidance" behavior, such as procrastinating in the morning before going to school, or complaining about physical discomforts (headaches, nausea, stomach ache). Very rarely do kids fake complaints of physical problems, says Young. "What's different is that their symptoms are caused by anxiety and fear, instead of a virus or bacteria." Younger-acting behavior for a period that goes on for weeks should raise suspicion. "In general, children under stress, regress," indicates Young.

Additional signs, such as complaints about a teacher or poor school performance, can also point to other problems, he warns. "The family has to understand their own particular child, and stay attuned to what behavior is normal for him. Gauge his adjustment based on your past experience and your expectations of that child."

Parents can help prepare kids for an easier transition to a new school by doing a little advance planning. "Anything that will change an unfamiliar, potentially scary experience into a familiar one will help a child," says Young. He recommends these steps:

- ✔ Visit the school before it opens up for the year. Most schools are open during the summer and the parent can ask for permission to walk around with the child. If the school system allows it, have the child meet the teacher before the end of the summer.
- ✔ If you've moved to a new neighborhood, help your child get to know the children who will be attending her school. Arrange a "buddy system" between your child and a peer from the new school.
- ✔ If your child will be riding the bus for the first time, take her for a visit to the bus company, or for a ride on public transportation.
- ✔ Inform the school if your child has special needs or requirements, such as a history of headaches or a learning disability. Parents are often hesitant to share this with the school because they're afraid the child will be labeled or stereotyped. But keeping this information from the school can deprive your child from the support she needs.

"Parents should view teachers as support agents for their child," stresses Young. "They have a lot of experience in dealing with problems associated with adapting to a new school. For parents to see the school as an ally is very helpful for the child."

If anxiety persists and problems turn from school avoidance to more serious issues, such as social isolation and depression, Young advises that parents seek help from a mental health professional. "In general, the time to seek help for the child is at the point where what you're seeing as a parent no longer feels comfortable. Parents can do a great deal in helping their children adapt to a new school simply by staying attentive to their concerns or changes in behavior."

This document is available on-line at http://www.ummed.edu/dept/main/resource/school.htm

Children and Anxiety

Thomas Huberty, Indiana University

National Association Of School Psychologists

✦Background

Anxiety is a familiar term and is a common experience for both children and adults at many times in their lives. For children, it is difficult to distinguish anxiety from fear, but generally anxiety is seen to be apprehension about future events that have not yet occurred. Fear, on the other hand, is a response to a situation, such as a child being afraid of an animal. The focus of this discussion is on anxiety, which is a feeling of apprehension without any apparent cause. Anxiety is a normal experience for all of us at one time or another, and becomes a concern when it becomes excessive and/or interferes with one's typical daily routine. Anxiety can be experienced by a person as a long-term feeling or it may occur in a specific setting, such as when taking a test.

Anxiety may occur in response to specific situations such as speaking in front of a group, or be shown in many situations. Children who are referred to as "high-strung" may show some of the signs of anxiety. Some common characteristics of anxiety are oversensitivity to normal events, fear of future outcomes, concentration difficulties, distractibility, impulsiveness, inattention to schoolwork, excessive movement, sleeping problems, rapid breathing, nausea, headaches, stomachaches, unusual fatigue, and, in extreme cases, running away from a situation. Not all of these characteristics will be shown at one time, however, and all may be signs of other problems.

✦Development

Young children experience anxiety normally as a process of growing up. Infants tend to feel anxiety about falling, loud noises, and having physical needs met. Anxiety in infants is shown in generalized activity that becomes more specific with age. At about 7-9 months of age, babies start to show anxiety of new people. It is at this point that the child can distinguish typical caretakers from strangers and he/she is apprehensive (anxious) about the absence of familiar persons. This form of anxiety is shown by refusing to be held by strangers, clinging to parents, and crying when alone with unfamiliar people. This "stranger anxiety" usually ends by about 12-14 months. At about 18-24 months, children demonstrate a related type of anxiety called "separation anxiety." This anxiety is shown by crying, temper tantrums, and attempting to cling to parents or caretakers. While this form of anxiety appears to be similar to stranger anxiety, it is different from the child's perspective. The anxiety is not a response to what might happen to the child if held by a stranger, but to the possibility that the parents might not return and to what might be the consequences of their not returning. By the time children enter school, these forms of anxiety ordinarily have dissipated and the child is more secure about being with strangers and not concerned about being left by parents.

As children progress in school, they tend to become anxious about being accepted by peers, overall school performance, expectations set by parents, physical appearance, and feelings of competence. They also may hold increased anxiety about the stability of

family relationships, death, and the future. Research has shown that girls tend to show more general anxiety than boys and more centered around social acceptance and popularity. The reasons for these findings are not clear, but may be related to the social roles that girls are expected to maintain in our society.

Recognizing the signs of anxiety and knowing when they indicate problems is not an easy task. If you see some signs of anxiety, the following questions should be considered:

- Is the anxiety typical for a child of that age?
- Is the anxiety seen across many situations or is it limited to a specific situation, such as speaking in front of the class?
- Is the anxiety of a long-term nature or has it occurred recently?
- Are there events going on in the child's life that are causing stress and pressure?
- Is the anxiety a sign of a larger problem, such as home and family difficulties?
- Is the anxiety having a great effect on the child's personal, social, and school functioning?

The last question is the most important, because if the child is having difficulty with everyday activities, the problems must be addressed regardless of their cause. By attending to the degree to which anxiety might be interfering with the child's functioning, answers to the other questions will become important in determining the nature, scope, and source of the child's anxiety. Once the entire situation is understood, then plans to work with the anxiety can be developed.

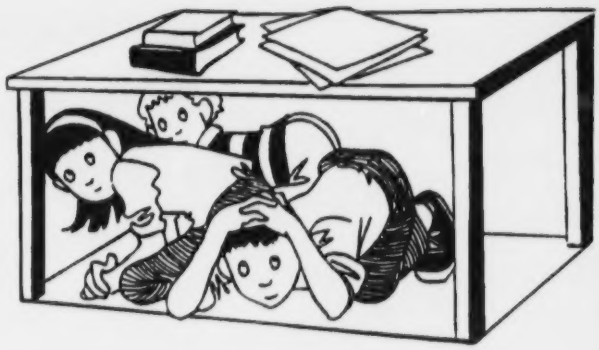
✦The Causes of Anxiety

The potential causes of anxiety are many, but the primary characteristic is that the child or adolescent is uncertain about something that has not yet happened. It matters little that the anxiety about a situation may not be realistic or justified. As long as someone feels uncertain whether something in the future might have a direct effect, he/she may become anxious. Anxiety is most likely to be shown when the person feels that something bad will happen and that they have no control over it. It is when people are apprehensive about the future and feel unable to do anything about it that anxiety is most likely to occur.

Nearly any event or circumstance can cause anxiety by creating a situation in which the person cannot predict an outcome and feels unable to make significant changes. Family problems (e.g., pending divorce, competition with siblings), excessive or unusual discipline practices, inconsistency in how children are handled or treated by adults, high expectations and standards set up by the child or others that are perceived to be unattainable, peer pressure to conform or "fit in," rejection (or, in some cases, acceptance as the child must now meet new expectations) by peers, high needs for achievement, concerns about success or failure, physical appearance, and ability level in a variety of areas are some of the factors that can contribute to the development of anxiety in children. It should be noted that anxiety often is shown in these situations, which is normal. Anxiety becomes problematic when it becomes so intense that the child's personal-social and/or school functioning begins to deteriorate.

Sometimes, there may be more than one factor contributing to the child's anxiety. The author once was asked to consult with school personnel about a 15-year old girl who complained of "test anxiety" in which she "froze" when taking a test. It was determined that she was indeed so afraid of getting a low grade that she could not perform. Moreover, she was concerned about disapproval from her mother if she got a low grade, and that she would have to compete even more with her new stepfather whom her mother had recently married...

Behavior Management & Self-Instruction for...



Managing Traumatic Stress

Tips for Recovering From Disasters and Other Traumatic Events*

Because you are reading this fact sheet you probably are in the process of recovering from a natural disaster or other type of traumatic event. Perhaps you experienced a flood, hurricane, or earthquake. Or maybe you have been in a serious accident or the victim of crime. Traumatic experiences such as these tend to be sudden and overwhelming. In some cases there are no outwardly visible signs of physical injury but there is nonetheless a serious emotional toll. It is common for people who have experienced traumatic situations to have very strong emotional reactions. Understanding normal responses in these abnormal events can aid you in coping effectively with your feelings, thoughts, and behaviors and help you along the path to recovery.

What happens to people after a disaster or other traumatic event?

Shock and denial are typical responses to disasters and other kinds of trauma, especially shortly after the event. Both shock and denial are normal, protective reactions.

Shock is a sudden and often intense disturbance of your emotional state that may leave you feeling stunned or dazed. Denial involves your not acknowledging that something very stressful has happened, or not experiencing fully the intensity of the event. You may temporarily feel numb or disconnected from life.

As the initial shock subsides, reactions vary from one person to another. The following, however, are normal responses to a traumatic event:

Feelings become intense and sometimes are unpredictable. You may become more irritable than usual, and your mood may change back and forth dramatically. You might be especially anxious or nervous, or even become depressed.

Thoughts and behavior patterns are affected by the trauma. You might have repeated and vivid memories of the event. These flashbacks may occur for no apparent reason and may lead to physical reactions such as rapid heart beat or sweating.

You may find it difficult to concentrate or make decisions, or become more easily confused. Sleep and eating patterns also may be disrupted.

Recurring emotional reactions are common. Anniversaries of the event, such as at one month or one year, as well as reminders such as aftershocks from earthquakes or the sounds of sirens, can trigger upsetting memories of the traumatic experience. These "triggers" may be accompanied by fears that the stressful event will be repeated.

Interpersonal relationships often become strained. Greater conflict, such as more frequent arguments with family members and coworkers, is common. On the other hand, you might become withdrawn and isolated and avoid your usual activities.

Physical symptoms may accompany the extreme stress. For example, headaches, nausea and chest pain may result and may require medical attention. Pre-existing medical conditions may worsen due to the stress.

How do people respond differently over time?

It is important for you to realize that there is not one "standard" pattern of reaction to the extreme stress of traumatic experiences. Some people respond immediately, while others have delayed reactions—sometimes months or even years later. Some have adverse effects for a long period of time, while others recover rather quickly.

And reactions can change over time. Some who have

suffered from trauma are energized initially by the event to help them with the challenge of coping, only to later become discouraged or depressed.

A number of factors tend to affect the length of time required for recovery, including:

- **The degree of intensity and loss.** Events that last longer and pose a greater threat, and where loss of life or substantial loss of property is involved, often take longer to resolve.

- **A person's general ability to cope with emotionally challenging situations.** Individuals who have handled other difficult, stressful circumstances well may find it easier to cope with the trauma.

- **Other stressful events preceding the traumatic experience.** Individuals faced with other emotionally challenging situations, such as serious health problems or family-related difficulties, may have more intense reactions to the new stressful event and need more time to recover.

How should I help myself and my family?

There are a number of steps you can take to help restore emotional well being and a sense of control following a disaster or other traumatic experience, including the following:

- **Give yourself time to heal.** Anticipate that this will be a difficult time in your life. Allow yourself to mourn the losses you have experienced. Try to be patient with changes in your emotional state.

- **Ask for support from people who care about you** and who will listen and empathize with your situation. But keep in mind that your typical support system may be weakened if those who are close to you also have experienced or witnessed the trauma.

Communicate your experience in whatever ways feel comfortable to you—such as by talking with family or close friends, or keeping a diary.

- **Find out about local support groups** that often are available such as for those who have suffered from natural disasters, or for women who are victims of rape. These can be especially helpful for people with limited personal support systems.

Try to find groups led by appropriately trained and experienced professionals. Group discussion can help people realize that other individuals in the same circumstances often have similar reactions and emotions.

- **Engage in healthy behaviors** to enhance your ability to cope with excessive stress. Eat well-balanced meals and get plenty of rest. If you experience ongoing difficulties with sleep, you may be able to find some relief through relaxation techniques. Avoid alcohol and drugs.

- **Establish or reestablish routines** such as eating meals at regular times and following an exercise program. Take some time off from the demands of daily life by pursuing hobbies or other enjoyable activities.

- **Avoid major life decisions** such as switching careers or jobs if possible because these activities tend to be highly stressful.

- **Become knowledgeable about what to expect** as a result of trauma. Some of the "Additional Resources" listed at the end of this fact sheet may help you with this learning process.

How do I take care of children's special needs?

The intense anxiety and fear that often follow a disaster or other traumatic event can be especially troubling for children. Some may regress and demonstrate younger behaviors such as thumb sucking or bed wetting. Children may be more prone to nightmares and fear of sleeping alone. Performance in school may suffer. Other changes in behavior patterns may include throwing tantrums more frequently, or withdrawing and becoming more solitary.

There are several things parents and others who care for children can do to help alleviate the emotional consequences of trauma, including the following:

- **Spend more time with children and let them be more dependent on you** during the months following the trauma - for example, allowing your child to cling to you more often than usual. Physical affection is very comforting to children who have experienced trauma.

- **Provide play experiences to help relieve tension.** Younger children in particular may find it easier to share their ideas and feelings about the event through non-verbal activities such as drawing.

- **Encourage older children to speak** with you, and with one another, about their thoughts and feelings. This

helps reduce their confusion and anxiety related to the trauma. Respond to questions in terms they can comprehend. Reassure them repeatedly that you care about them and that you understand their fears and concerns.

- **Keep regular schedules** for activities such as eating, playing and going to bed to help restore a sense of security and normalcy.

When should I seek professional help?

Some people are able to cope effectively with the emotional and physical demands brought about by a natural disaster or other traumatic experience by using their own support systems. It is not unusual, however, to find that serious problems persist and continue to interfere with daily living. For example, some may feel overwhelming nervousness or lingering sadness that adversely affects job performance and interpersonal relationships.

Individuals with prolonged reactions that disrupt their daily functioning should consult with a trained and experienced mental health professional. Psychologists and other appropriate mental health providers help educate people about normal responses to extreme stress. These professionals work with individuals affected by trauma to help them find constructive ways of dealing with the emotional impact.

With children, continual and aggressive emotional outbursts, serious problems at school, preoccupation with the traumatic event, continued and extreme withdrawal, and other signs of intense anxiety or emotional difficulties all point to the need for professional assistance. A qualified mental health professional can help such children and their parents understand and deal with thoughts. feelings and behaviors that result from trauma.

How may I use APA as a resource?

"How to Choose a Psychologist," brochure available from the American Psychological Association (APA). To order a copy free of charge, write to the APA Office of Public Communications. 750 First Street, NE, Washington, DC 20002-4242, or call (202) 336-5700.

Contact the **APA Practice Directorate** at (202) 336-5800 for the name and telephone number of your **state psychological association.** These associations, along with **city and county psychological associations,** can refer you to psychologists in your area. They may also be able to put you in touch with **other local organizations and groups that help victims of disasters and other traumatic events.**

"Helping Children Cope," may be accessed via the APA home page on the Internet, at http://www.apa.org/kids.html

Additional Resources

Local chapters of the American Red Cross may be able to direct you to additional resources. Check your local telephone directory for the chapter nearest you.

National **Organization for Victims Assistance.** 1757 Park Rd.., NW, Washington, D.C. 20010; toll-free, 1-800-TRY-NOVA: in D.C. metropolitan area, (202) 232-6682.

Two other materials available via Internet offer additional information about coping with disaster:

"After a Disaster: Steps You Can Take to Cope With a Stressful Situation," Los Angeles County Department of Mental Health http://gladstone.uoregon.edu/~dvb/disasteps.htm

"Coping with Emotions after a Disaster," University of Illinois Cooperative Extension Service http:www.ag.uiuc.edu/~disaster/emotion.html

AMERICAN PSYCHOLOGICAL ASSOCIATION
Practice Directorate
750 First Street, NE
Washington, DC 20002-4242
202/336 5898
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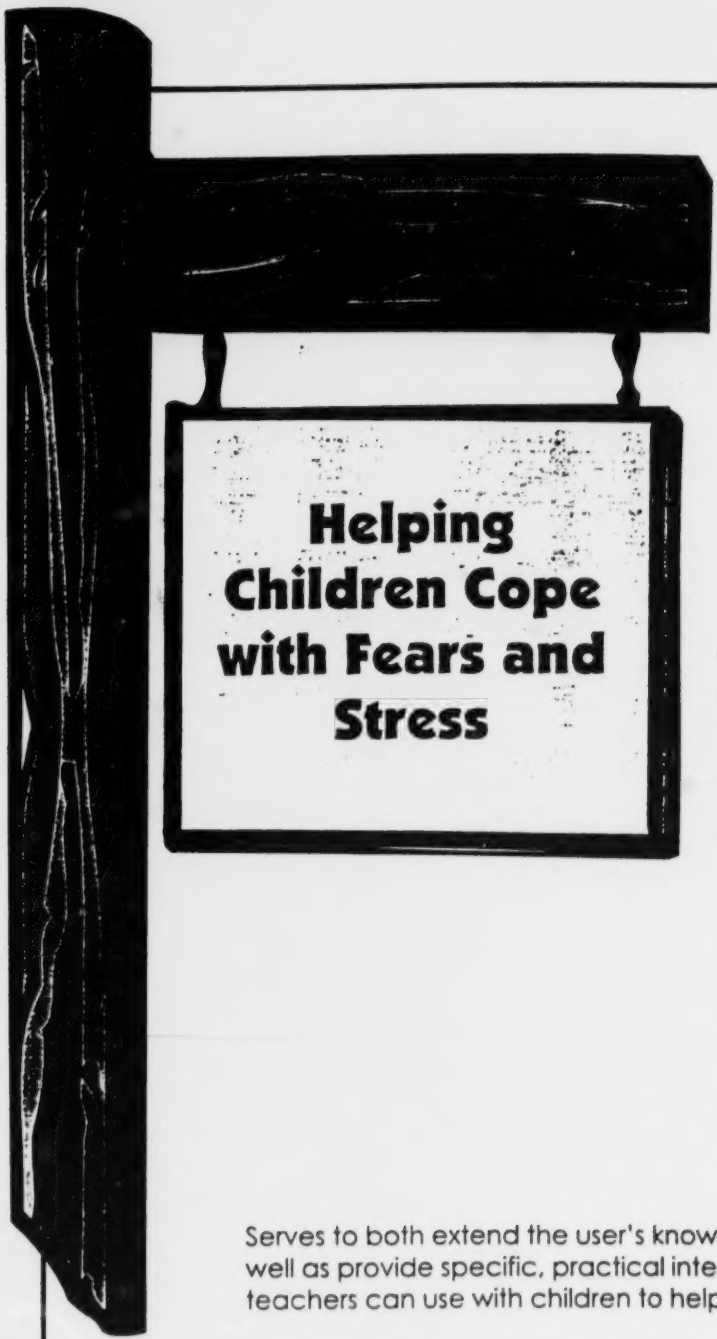

Helping Children Cope with Fears and Stress

by:
Edward H. Robinson
Joseph C. Rotter
Mary Ann Fey
Kenneth R. Vogel

This handbook offers to counselors and teachers:

❶ a concise overview of children's fears and stress,

❷ 47 activities and strategies for individual and group counseling interventions for easy integration into the K-8 curriculum, and

❸ a facilitators guide detailing an eight session workshop for training teachers and counselors on how to help children cope with fears and stress.

Serves to both extend the user's knowledge of children's fears and stress as well as provide specific, practical interventions which counselors and teachers can use with children to help them cope more effectively.

For more information contact:
ERIC Counseling and Student Services Clearinghouse
School of Education
University of North Carolina at Greensboro
Greensboro, NC 27412-5001
(800)414-9769

Empirically Supported Treatments

In an effort to improve the quality of treatment, the mental health field is promoting the use of empirically supported interventions. The following pages contain *excerpts* from a 1998 report entitled "Empirically Supported Treatments for Children With Phobic and Anxiety Disorders: Current Status" by T. H. Ollendick and N. J. King, which appears in the *Journal of Clinical Child Psychology, 27*, 156-167.

Excerpted here are the abstract, key summary tables and conclusions, and the authors' references.

Abstract of article by T. H. Ollendick and N. J. King, which appears in the *Journal of Clinical Child Psychology, 27*, 156-167.

Reviews the empirically supported status of behavioral and cognitive-behavioral interventions in the treatment of childhood phobias and anxiety disorders. For childhood phobias, it is concluded that imaginal desensitization, in vivo desensitization, filmed modeling, live modeling, and cognitive behavioral interventions that use self-instruction training are probably efficacious and that participant modeling and reinforced practice are well established. For anxiety disorders, only cognitive-behavioral procedures with and without family anxiety management (FAM) were found to be probably efficacious. However, much of the support for these procedures come from analogue studies conducted in research laboratories or school settings, delivered in small group format and, not infrequently, with nonclinically referred children. Additional research that examines high-strength interventions with clinic-referred children is recommended. Furthermore, research that examines the pathological processes involved in the onset and maintenance of phobic and anxiety disorders as well as the change processes used to treat these disorders is called for.

The following pages highlight the gist of the article.

* * *

Childhood Fears and Phobias

Systematic Desensitization and Its variants

Wolpe (1958) first formulated the systematic desensitization procedure. In this paradigm, fears and phobias are viewed as classically conditioned responses that can be unlearned through specific counterconditioning procedures. In *counterconditioning,* fear-producing stimuli are presented imaginally or in vivo (real life) in the presence of other stimuli that elicit responses incompatible with fear. In this manner, the fear is said to be counterconditioned and inhibited by the incompatible response. In its most basic form, systematic desensitization consists of three components: (a) induction of an incompatible response (e.g., relaxation); (b) development of a fear-producing hierarchy; and (c) the systematic, graduated pairing of items in the hierarchy with the incompatible response. Generally, fear-producing stimuli are presented imaginally (in order of least to most fear producing) while the child is engaged in an incompatible behavior (e.g., relaxation). This aspect of treatment is the desensitization proper and is thought to lead to direct inhibition of the fear response. Although studies have questioned the active mechanisms and the necessary ingredients of systematic desensitization (see review by Ollendick, 1979) there is little doubt that this desensitization and its variants are frequently used procedures with children...

In sum, imaginal systematic desensitization has been found to be more effective than no treatment in four between-group design studies (Barabasz, 1973; Kondas, 1967; Mann & Rosenthal, 1969; Miller et al., 1972). Furthermore it has been found to be more effective than some alternative treatments (e.g., relaxation training) but not others (e.g., live modeling). On the basis of these studies, imaginal systematic desensitization can be said to enjoy probably efficacious status...

Modeling and Its Variants

Drawing on vicarious conditioning principles, modeling capitalizes on the power of observational learning to overcome children's fears and phobias. The theoretical and empirical bases of modeling as a treatment procedure have been articulated by Bandura and his colleagues (e.g., Bandura, 1971). Theoretically, the extinction of avoidance responses is thought to occur through observation of modeled approach behavior directed toward a feared stimulus without adverse consequences accruing to the model. In its most basic procedural form, it entails demonstrating nonfearful behavior in the anxiety-provoking situation and showing the child a more adaptive and appropriate response for handling or dealing with the feared object or event. Modeling can be symbolic (filmed) or live; furthermore, the phobic child can be assisted in approaching the feared stimulus (participant modeling) or prompted to display the modeled behavior without such assistance. In all of these procedural variations, anxiety is thought to be reduced and a new skill to be acquired (Bandura, 1969)...

Thus, on the basis of these nine studies, it can be concluded that filmed modeling and live modeling are probably efficacious procedures. Both have been shown to be superior to no-treatment conditions with a variety of excessive fears and phobias. Participant modeling, on the other hand, enjoys well-established status. It is more effective than filmed and live modeling as well as standard (imaging) systematic desensitization.

Contingency Management

In contrast to systematic desensitization, modeling, and their variants, which all assume that fear must be reduced or eliminated before approach behavior will occur, contingency management procedures make no such assumption. Derived from principles of operant conditioning, contingency management procedures attempt to alter phobic behavior by manipulating its consequences (King & Ollendick, 1997). Operant-based procedures assert that acquisition of approach responses to the fear-producing situation is sufficient and that anxiety reduction, per se, is not necessary. Shaping, positive reinforcement and extinction are the most frequently used contingency

management procedures to reduce phobic behavior...

Thus, on the basis of these four between-group design studies, it can be concluded that reinforced practice has also earned well-established status: It has been shown to be more effective than no-treatment control conditions in two studies (Leitenberg & Callahan, 1973; Obler & Terwilliger, 1970) and to be superior to two other treatment modalities--verbal coping skills (Sheslow, et al., 1983) and live (adult) modeling (Menzies & Clarke, 1993), both of which have been shown to be more effective than no treatment.

Cognitive-Behavioral Procedures

Cognitive-behavioral procedures include a variety of strategies designed to alter perceptions, thoughts, images, and beliefs of phobic children by manipulating and restructuring their distorted, maladaptive cognitions. Because these maladaptive cognitions are assumed to lead to maladaptive behavior (e.g., phobic avoidance), it is asserted that cognitive changes will produce behavior changes.

Results from these two between-group studies indicate that interventions based on self-instructional training and related cognitive procedures are more effective than no-treatment and wait-list control groups. However, they have not been systematically compared to other treatments, and as a result, they can only be viewed as probably efficacious at this time. Their well-established status awaits additional research.

Summary

On the basis of this brief review, a variety of behavioral and cognitive-behavioral interventions have been shown to be more effective in the treatment of childhood fears and phobias than wait-list control conditions. In addition, some of these interventions have been shown to be superior to placebo or other treatments. As indicated in Table 1, imaginal desensitization, in vivo desensitization, filmed modeling, live modeling, and self-instruction training all enjoy probably efficacious status. Moreover, participant modeling and reinforced practice enjoy well-established status. Emotive imagery, on the other hand, can only be described as experimental at this time. Having noted those generally positive outcomes, however, it should be quickly asserted

Table 1. *Summary of EST Status of Behavioral and Cognitive-Behavioral Treatments for Phobias and Anxiety Disorders in Children and Adolescents*

Treatment	EST Status
For Phobias	
Systematic Desensitization and Its variants	
Imaginal Desensitization	Probably Efficacious
In Vivo Desensitization	Probably Efficacious
Emotive Imagery	Experimental
Modeling and Its Variants	
Live Modeling	Probably Efficacious
Filmed Modeling	Probably Efficacious
Participant Modeling	Well-Established
Operant Procedures	
Reinforced Practice	Well-Established
Cognitive-Behavioral Procedures	
Cognitive-Behavior Therapy	Probably Efficacious
For Anxiety Disorders	
Cognitive Behavioral Procedures	
Cognitive-Behavior Therapy	Probably Efficacious
Cognitive-Behavior Therapy + Family Anxiety Management	Probably Efficacious

that even these behavioral and cognitive-behavioral procedures are in need of considerable additional empirical support. Extant support is meager at best. Although children were randomly assigned to treatment conditions in the studies reviewed, characteristics of the samples were only minimally specified (e.g., age, sex, diagnosis/extent of fear), adequate statistical

power was notably lacking (the sample sizes were small in most studies) and only rarely were manuals used in treatment. (However, note that the bulk of these studies were completed prior to the advent of manualization and that, for the most part, procedures were sufficiently specified to permit replication and validation.) Moreover, as evident in Table 2, much of the support has come from analogue studies that have been conducted in research or school settings and delivered in small-group format and, not infrequently, with nonclinically referred children. As such, the children and the treatment in many of these studies may have differed substantially from that offered in clinic settings to clinic-referred children and their families (see Kazdin, 1997; Weisz, Donenberg, Han, & Weiss, 1995; Weisz, Weiss, & Donenberg, 1992). Furthermore, studies examining the efficacy of "one-session" treatment (Ost, 1989) of specific phobias in children are notably lacking. A combination of exposure in vivo, modeling, and reinforced practice, this procedure has been found to be a rapid and effective treatment for phobias in adults (Ost; 1997). Its efficacy with children awaits systematic inquiry (Ollendick, Hagopian, & King, 1997). Finally, the efficacy of these treatments has not been examined with other anxiety disorders of childhood (e.g., separation anxiety disorder, generalized anxiety disorder, panic disorder). Their use has been restricted to clinical fears and phobias.

Anxiety Disorders

Surprisingly, no controlled between-group design studies examining the efficacy of psychotherapy with children evincing anxiety disorders, other than simple or specific phobias, existed until recent years (Hagopian & Ollendick, 1997). Nonetheless several single-case design studies provided preliminary evidence for the likely utility of behavioral and cognitive-behavioral procedures with overanxious and separation anxious youth (e.g., Eisen & Silverman, 1993; Hagopian, Weist, & Ollendick, 1990; Kane & Kendall, 1989; Ollendick, 1995; Ollendick, Hagopian, & Huntzinger, 1991). These early studies provided the foundation for the between-group design studies that followed. Four such between-group studies have been undertaken in recent years. All evaluate the efficacy of cognitive-behavioral therapy.

Cognitive-behavioral treatment (CBT) for anxiety disorders in children, as pioneered by Kendall and his colleagues (e.g., Kendall et al., 1992), is focused on four major cognitive components (a) recognizing anxious feelings and somatic reactions to anxiety, (b) clarifying cognitions in anxiety-provoking situations (i.e., unrealistic or negative attributions or expectations), (c) developing a plan to help cope with the situation (i.e., modifying anxious self-talk as well as determining what coping actions might be effective), and (d) evaluating the success of the coping strategies and self-reinforcement as appropriate. These cognitive strategies are used to assist the child to recognize anxious cognitions, to use awareness of these cognitions as cues for managing their anxiety, and to help them cope more effectively in anxiety-provoking situations.

In addition, behavioral strategies such as modeling, in vivo exposure, role play, relaxation training, and reinforced practice are used (Kane & Kendall, 1989; Kendall et. al., 1992). Thus, these cognitive-behavioral procedures are broad in scope and incorporate many of the elements of treatments used with phobic children...

Summary

Based on these four, well-controlled, between-group design studies, it is evident that cognitive-behavioral therapy alone and cognitive-behavior therapy plus family anxiety management are probably efficacious in the treatment of anxiety disorders in children. Moreover, preliminary evidence suggests the inclusion of the family anxiety management component will enhance CBT's efficacy and result in a well-established treatment. Such a conclusion is consistent with recent experimental evidence that affirms the role of family (especially parental) enhancement of avoidant responses in anxious children (see Barrett, Rapee, Dadds & Ryan, 1996; Dadds, Berrett, Rapee, & Ryan, 1996) and the need to involve family members more centrally in the therapeutic process with anxious children (see Ginsburg, Silverman, & Kurtines 1995; Ollendick & Ollendick, 1997).

The studies to date, using what Kazdin (1993) referred to as "treatment package" and "constructive treatment" evaluative strategies, provide an affirmative response to the question, Does treatment (CBT) produce therapeutic change? In the case of CBT, What components or other treatments can be added to enhance therapeutic change (i.e., family anxiety management)? However, many questions about the effectiveness of treatment remain, including what processes within treatment influence (mediate) outcome and what child, parent, family, and contextual features influence (moderate) outcome (Kazdin, 1997).

A host of clinical issues salient to the implementation and evaluation of these treatments also remain (see Ollendick & Ollendick, 1997; Silverman, Ginsburg, & Kurtines, 1995).

Table 2: *EST Criteria and the Status of Behavioral and Cognitive-Behavioral Treatments of Fear and Phobias in Children and Adolescents*

	Superior to Pill, Placebo, or Other Treatments	Equivalent to Established Treatment	Superior to Waitlist Control Group	Treatment Manual	Client Characteristics Specified	Clinical Analogue
Systemic Desensitization and Its Variants						
Imaginal Desensitization						
Kondas (1967)	Yes[a]	NA	Yes	No	Yes	Analogue
Mann & Rosenthal (1969	No[b]	NA	Yes	No	Yes	Analogue
Barabasz (1973)	NA	NA	Yes	No	Yes	Analogue
Miller et al. (1972)	No[c]	NA	Yes	No	Yes	Clinical
In Vivo Desensitization						
Ultee et al. (1982)	Yes[d]	NA	Yes	No	Yes	Clinical
Kuroda (1969)	NA	NA	Yes	No	Yes	Analogue
Emotive Imagery						
Cornwall et al. (1997)	NA	NA	Yes	No	Yes	Clinical
Modeling and Its Variants						
Live Modeling						
Mann & Rosenthal (1969)	No[b]	NA	Yes	No	Yes	Analogue
Bandura et al. (1967)	Yes[e]	NA	Yes	No	Yes	Analogue
Filmed Modeling						
Bandura & Menlove (1968)	NA	NA	Yes	No	Yes	Analogue
Hill et al. (1968)	NA	NA	Yes	No	yes	Analogue
Participant Modeling						
Lewis (1974)	Yes[f]	NA	Yes	No	Yes	Clinical
Ritter (1968)	Yes[g]	NA	Yes	No	Yes	Analogue
Bandura et al. (1969)	Yes[h]	NA	Yes	No	Yes	Clinical
Blanchard (1970)	NA	NA	Yes	No	Yes	Clinical
Murphy & Bootzin (1973)	NA	NA	Yes	No	Yes	Analogue
Operant Procedures						
Olber & Terwilliger (1970)	NA	NA	Yes	No	Yes	Clinical
Leitenberg & Callahan (1973)	NA	NA	Yes	No	Yes	Analogue
Sheslow et al. (1983)	Yes[i]	NA	Yes	No	Yes	Clinical
Menzies & Clark (1993)	Yes[j]	NA	Yes	No	Yes	Clinical
Cognitive-Behavioral Procedures						
Kanfer et al. (1975)	Yes[k]	NA	Yes	No	Yes	Analogue
Graziano & Mooney (1980)	NA	NA	Yes	No	Yes	Clinical

NOTE: [a]Imaginal desensitization > relaxation training. [b]Imaginal desensitization = live modeling. [c]imaginal desensitization = psychotherapy. [d]In vivo desensitization > imaginal desensitization. [e]Live modeling = imaginal desensitization; both > positive placebo context. [f]Participant modeling > filmed modeling. [g]Participant modeling > filmed modeling. [h]Participant modeling > filmed modeling; participant modeling > imaginal desensitization. [i]Reinforced practice > verbal self-instruction. [j]Reinforced practice > live modeling. [k]Competence statements > stimulus statements > neutral statements.

Conclusions and Future Directions

At this juncture, it appears critical that we take additional steps to establish truly clinically efficacious treatments for children with phobic and anxiety disorders. Integrated treatments proposed early on by Ollendick (1979) and illustrated in the recent work of Heard, Dadds, and Conrad (1992) represent such efforts and show considerable promise. Heard, et al. (1992), for example, designed an integrated treatment package for phobic children consisting of in vivo exposure, participant modeling, reinforced practice, self-instruction training, and home contingency management. Results on self-report, parent-report, and behavioral measures affirmed the effectiveness of the integrated procedures, in addition, family functioning in terms of cohesion increased as a result of treatment. The development and evaluation of such high-potency, "total push" interventions with clinic-referred children seem critical as our next step. Both well-controlled, single-case designs and full-fledged, randomized clinical trials will likely prove useful in this regard. Subsequent to demonstrated efficacy with such interventions, dismantling and parametric studies might follow to establish critical components of the treatment packages, as suggested by Kazdin (1997). In such studies, it will also be necessary to specify treatment procedures (preferably through manualization) and to determine whether the treatments actually alter those processes that are conceptualized as critical in the treatment model (e.g., do changes in self-efficacy for dealing with agoraphobic avoidance or changes in distorted cognitions actually occur in cognitive-behavioral intervention; see Eisen & Silverman, 1993; Ollendick, 1995). Hypothesized treatment processes, of course, should also be linked to the conceptualization of the psychopathological processes involved in the etiology of the disorder, as suggested by Shirk and Russell (1996). Basically, the treatment should match or address the processes hypothesized to be related to the onset and maintenance of the disorder. The goodness of fit of such an intervention should be related to treatment outcome. Finally, it also will be necessary to explore the boundary conditions under which the interventions are found to be effective (i.e., establish the moderators of effective treatment outcome). The phrase "what works for whom and under what conditions" has long been espoused; however, it has rarely been realized.

In sum, limited progress has been made in development of efficacious treatment procedures for children with anxiety and phobic disorders. Much remains to be accomplished. Although one is tempted to conclude that we simply need more research, such a conclusion would be ill-advised and short-sighted. We do need more research, but we do not need more research like that which has been conducted in the past. Rather we need more research that is methodologically sound and that extends the evaluation of our treatment procedures to clinic-referred children in clinic settings, much like the research that has occurred in the recent studies conducted by Kendall and colleagues. That is a start. In addition, we need qualitatively different research that addresses processes and outcomes in a more sophisticated and conceptually rich manner in order to make significant advances. The challenge lies before us.

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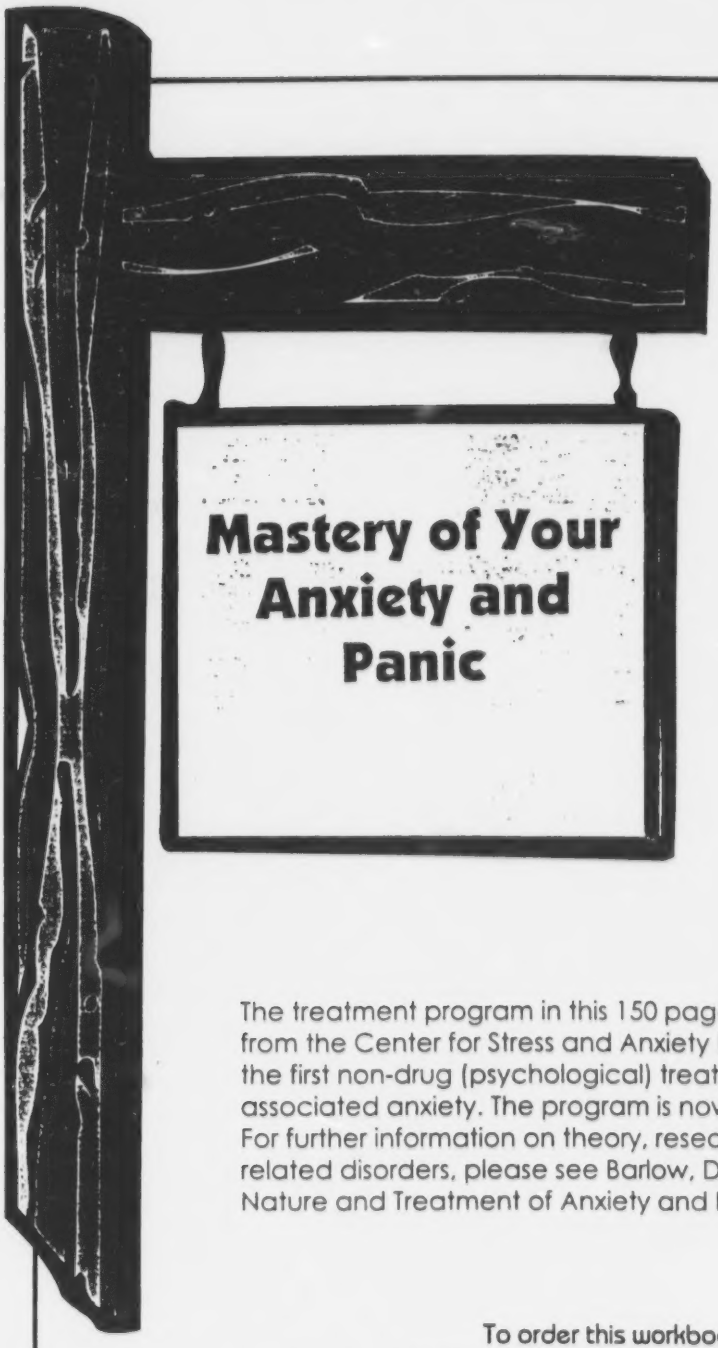

Mastery of Your
Anxiety and Panic

by:
David Barlow Ph.D.
Michelle Craske Ph.D.

The treatment program in this 150 page manual represents a development from the Center for Stress and Anxiety Disorders . This program represents the first non-drug (psychological) treatment for panic attacks and associated anxiety. The program is now available in this workbook format. For further information on theory, research and treatment of anxiety and related disorders, please see Barlow, D.H. Anxiety and Its Disorders: The Nature and Treatment of Anxiety and Panic. New York: Guilford Press.

To order this workbook, contact:
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MEDICATION AND ANXIETY DISORDERS

From the National Institute of Mental Health Website: Http://www.nimh.nih.gov/publicat/
The material has been abridged for use here to highlight information about psychotropic medication frequently prescribed for children and adolescents.

Individuals with anxiety disorders may feel anxious most of the time, without any apparent reason. Or the anxious feelings may be so uncomfortable that to avoid them the individual may stop some everyday activities. Some individuals have occasional bouts of anxiety so intense they terrify and immobilize them.

Anxiety disorders are the most common of all the mental disorders. At the National Institute of Mental Health (NIMH)--the Federal agency that conducts and supports research related to mental disorders, mental health, and the brain--scientists are learning more and more about the nature of anxiety disorders, their causes, and how to alleviate them. NIMH also conducts educational outreach activities about anxiety disorders and other mental illnesses.

Generalized Anxiety Disorder

Generalized anxiety disorder (GAD) is much more than the normal anxiety people experience day to day. It is characterized as chronic and exaggerated worry and tension, even though nothing seems to provoke it. Having this disorder means always anticipating disaster, often worrying excessively about health, money family or work. Sometimes, though, the source of the worry is hard tc pinpoint. Simply the thought of getting through the day provokes anxiety.

Panic Disorder

People with panic disorder have feelings of terror that strike suddenly and repeatedly with no warning. They can't predict when an attack will occur, and many develop intense anxiety between episodes, worrying when and where the next one will strike. In between times there is a persistent, lingering worry that another attack could come any minute.

Panic disorder is often accompanied by other conditions such as depression or alcoholism, and may spawn phobias, which can develop in places or situations where panic attacks have occurred. For example, if a panic attack strikes while you're riding an elevator, you may develop a fear of elevators and perhaps start avoiding them. Some people find the greatest relief from panic disorder symptoms when they take certain prescription medications. Such medications, like cognitive-behavioral therapy, can help to prevent panic attacks or reduce their frequency and severity. Two types of medications that have been shown to be safe and effective in the treatment of panic disorder are antidepressants and benzodiazepines.

Phobias

Phobias occur in several forms. A specific phobia is a fear of a particular object or situation. Social phobia is a fear of being painfully embarrassed in a social setting. And agoraphobia, which often accompanies panic disorder, is a fear of being in any situation that might provoke a panic attack, or from which escape might be difficult if one occurred.

About 80 percent of people who suffer from social phobia find relief from their symptoms when treated with cognitive-behavioral therapy or medications or a combination of the two. Therapy may involve learning to view social events differently; being exposed to a seemingly threatening social situation in such a way that it becomes easier to face; and learning anxiety-reducing techniques, social skills, and relaxation techniques. The medications that have proven effective include antidepressants called MAO inhibitors. People with a specific form of social phobia called performance phobia have been helped by drugs called beta-blockers. For example, musicians or others with this anxiety may be prescribed a beta-blocker for use on the day of a performance.

Obsessive-Compulsive Disorder

Obsessive-compulsive disorder is characterized by anxious thoughts or rituals you feel you can't control. If you have OCD, as it's called, you may be plagued by persistent, unwelcome thoughts or images, or by the urgent need to engage in certain rituals.

Research by NIMH-funded scientists and other investigators has led to the development of medications and behavioral treatments that can benefit people with OCD. A combination of the two treatments is often helpful for most patients. Some individuals respond best to one therapy, some to another. Two medications that have been found effective in treating OCD are clomipramine and fluoxetine.

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) is a debilitating condition that follows a terrifying event. Often, people with PTSD have persistent frightening thoughts and memories of their ordeal and feel emotionally numb, especially with people they were once close to. PTSD, once referred to as shell shock or battle fatigue, was first brought to public attention by war veterans, but it can result from any number of traumatic incidents.

Antidepressants and anxiety-reducing medications can ease the symptoms of depression and sleep problems, and psychotherapy, including cognitive-behavioral therapy, is an integral part of treatment. Being exposed to a reminder of the trauma as part of therapy -- such as returning to the scene of a rape -- sometimes helps. And, support from family and friends can help speed recovery.

PSYCHOTROPIC MEDICATIONS CATEGORIZED BY CHILD /ADOLESCENT DIAGNOSIS*

This chart provides some brief information on psychotropic medications frequently prescribed for students. The medications are listed with respect to the diagnosis that leads to their prescription. For more information, see the *Physicians Desk Reference.*

Anxiety Disorders

Anti-depressants

Imipramine [Tofranil, Janimine]

Anxiolytics

Buspirone hydrochloride [BuSpar]
Chlordiazepoxide [Librium]
Alprazolam [Xanax]

Anti-histamines

Diphenhydramine [Benedryl]
Hydroxyzine hydrochloride [Atarax]
Hydroxyzine pamoate [Vistaril]

School Phobia

Anti-depressants

Imipramine [Tofranil, Janimine]

Anxiolytics

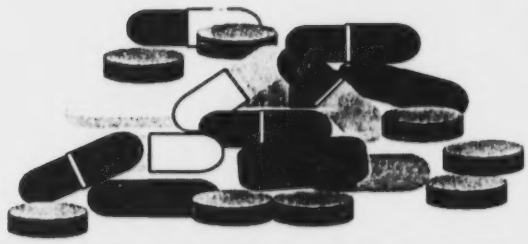
Chlordiazepoxide [Librium]
Alprazolam [Xanax]
Buspirone hydrochloride [BuSpar]

Obsessive-Compulsive Disorder

Anti-depressants:

Fluoxetine [Prozac]
Clomipramine hydrochloride [Anafranil]

*Because many side effects are not predictable, all psychotropic medication requires careful, ongoing monitoring of psychological and physical conditions. Pulse, blood pressure, and signs of allergic reactions need to be monitored frequently, and when medication is taken for prolonged periods, periodic testing of hematological, renal, hepatic, and cardiac functions are essential. Prior to any other physical treatment (surgery, dentistry, etc.), it is important to inform physicians/dentists that psychotropic medication is being taken. Finally, common side effects of many medications are drowsiness/insomnia and related factors that can interfere with effective school performance.



Names: Generic (Commercial)	Some Side Effects and Related Considerations
Benzodiazepines: (Ativan, Centrax, Klonopin, Librium, Paxipam, Serax, Tranxene, Valium, Xanax)	*Used in the treatment of GAD, Panic disorders and Social Phobias:* Potentially habit-forming; can cause drowsiness.
Beta Blockers: (Inderal, Tenormin)	*Used in the treatment of Social Phobias:* Should not be used with certain pre-existing medical conditions such as asthma, congestive heart failure, diabetes, vascular disease, hyperthyroidism, and angina pectoris.
Azaspirones: (BuSpar)	*Used in the treatment of GAD* Works slowly; Can't switch from benzodiazepines immediately
Monoamine Oxidase Inhibitors (MAOIs): (Eldepryl, Eutonyl, Marplan, Nardil, Parnate)	*Used in the treatment of Panic Disorders, Social Phobias, PTSD, OCD* Strict dietary restrictions and potential drug interactions; low blood pressure, moderate weight gain, reduced sexual response, insomnia.
Serotonin Reuptake Inhibitors (SRIs): (Desyrel, Prozac, Paxil, Zoloft, Serzone, Luvox, Effexor)	*Used for Panic Disorders and OCD* Nausea; some can cause nervousness; reports of delayed ejaculation
Tricyclic Antidepressants (TCAs): (Adapin, Sinequan, Janimine, Vivactil, Elavil, Pertofrane, Tofranil, Pamelor, Anafranil, Sermontil, Ludiomil)	*Used in the treatment of Panic Disorders, PTSD, OCD* Dry mouth, constipation, blurry vision, difficulty urinating, dizziness, low blood pressure; moderate weight gain.

School Mental Health Project
Center for Mental Health in Schools
Continuing Education
This document is available
on our website: http://smhp.psych.ucla.edu

School Avoidance: Reactive and Proactive

An enhanced conceptual base of the full range of factors causing student problems builds on contemporary motivational theory. School avoidance behavior, like the misbehavior described above, can be understood in terms of students' attempts to act in ways that make them feel in control, competent, and connected with significant others. The action may be overt, such as a direct refusal to attend, or covert, such as passive withdrawal and feigned illness.

The importance of distinguishing the underlying motivation for school avoidance behavior can be illustrated by thinking about three students who are school refusers.

Although others think Janet is afraid to attend school, in fact her avoidance is motivated by a desire to stay home with her mother. That is, she is proactively seeking to maintain her sense of relatedness with home and family. In contrast, Jeff refuses to attend as a direct protest against school rules and demands because he experiences them as a threat to his sense of self-determination; his avoidance is reactive. Joe's avoidance also is reactive; he lacks the skills to do many of the assigned tasks and becomes so anxious over this threat to his competence that he frequently runs out of the classroom.

Differentiating Among School Avoiders

In a study of school avoiders, Taylor and Adelman (1990) differentiated 5 groups. Of the five, four involve student proactive and reactive motivation; the fifth reflects a variety of needs related to family dynamics and events that may or may not result in a student wanting to avoid school. As with most subgroupings, the categories are not mutually exclusive.

1. Proactive attraction to alternatives to school. There are many aspects of a student's life at home and in the community that compete with school. For instance, there are children who miss school primarily because they want to stay home to be with a parent, grandparent, or younger sibling or because they have become hooked on TV programs or other favorite activities. And, of course, among junior and senior high students, there often is a strong pull to hang out with peers (truants and dropouts). From an intrinsic motivational perspective, such proactive attraction can occur because a youngster finds these circumstances produce feelings of relatedness, competence, or control over one's life that are much greater than those experienced at school.

2. Reactive avoidance of experiences at school that lead to feelings of incompetence or lack of relatedness (including lack of safety). In contrast to proactive avoidance, reactive avoidance (in its many forms) is to be anticipated whenever a student expects events to be negative and to result in negative feelings. Two specific areas of concern in this respect are events that lead to feelings of incompetence or lack of relatedness (including lack of safety) in the school context. In particular, it is not surprising that students who expect to encounter significant failure/punishment in their efforts to meet others' or their own academic and social standards come to perceive school as a threatening place. Such expectations may arise not only for individuals who have actual disabilities and skill deficits, but for any student who experiences

standards for learning, performance, and behavior that exceed her or his ability. These youngsters report feelings of embarrassment, of being different, of not being liked, of being left out, of being abused. Some avoid school whenever kickball is on the schedule because they know no one wants them on their team. Some refuse to attend because another student has singled them out to bully. And there are some who have moved to a new school and find they are not accepted by the peer group with whom they identify.

3. Reactive avoidance to control by others at school. When one feels that others are exerting inappropriate control, there may be a psychological reaction that motivates efforts to restore one's feeling of self-determination. There are a significant number of instances where school avoidance is an expression of a power struggle between teacher and student or parent and child. The more the teacher or parent tightens the limits and punishes the individual, the more the youngster seems committed to showing s/he can't be controlled. Some adopt the idea of refusing to go to school. In such cases, the more the parents threaten, take away privileges, and punish, the more the child's determination grows. The struggle often becomes a literal wrestling match to get a resistant child from the bed, into clothes, out to the car, and finally through the classroom door. Some parents and teachers end up winning a particular battle, but they usually find the struggle for control continues on many other fronts.

4. Reactive avoidance in response to overwhelming anxiety/fear. Although they represent a minority of the many youngsters who avoid school, for some individuals the term "phobic" is appropriate. Again, in some instances, the extreme anxiety/fear may be a reaction to expectations about finding oneself in circumstances where one will feel incompetent, lacking control, or loss (separation) or lack of relatedness to significant others. In true phobias, however, even the student's assessment of objective reality does not match his or her high degree of anxiety and fear. Such students report pervasive symptoms (e.g., sleeping problems, anxiety produced vomiting, uncontrollable crying). In addition, not uncommonly they have parents who themselves report strong fears and phobic behaviors. Even with extensive accommodations by teachers and parents, the fears of these students often continue to interfere with attending school, thus requiring major therapeutic intervention.

5. Needs related to family members and events. Parents have a number of reasons for keeping their youngsters home from school. For instance, some students are frequently absent because they have to babysit with younger siblings or be with ailing or lonely parents or grandparents. Crises in the home, such as death, divorce, or serious illness, can cause parents to keep their children close at hand for comfort and support. Under such circumstances, some youngsters are attracted to the opportunity to stay home to meet a parent's special needs or become frightened that something bad will happen to a family member when they are at school. Moreover, when life at home is in turmoil, students may feel they cannot bear the added pressure of going to school. Thus, crises at home, and a variety of other underlying family dynamics, can produce emotions in a youngster that lead to motivation for avoiding school.

Unfortunately, whatever the initial cause of nonattendance, the absences become a problem unto themselves. Of specific consequence is the fact that students quickly fall behind in their school work; grades plummet; there is a mounting sense of hopelessness and increased avoidance. Among adolescents, increasing avoidance can transition rapidly into dropping out of school.

As a note of caution, it is also important to alert staff to the fact that not all school avoidance stems from psychoeducational causes. For example, in one school avoidance case, the student complained of stomach pain. The parents, counselor, school nurse, school psychologist, and the student herself assumed this simply was a physical symptom of anxiety related to pressure at school. However, the school nurse insisted on a thorough physical examination that found the pain was a pre-ulcer symptom. Medication controlled the symptom, and regular school attendance resumed.

Intervention Overview

Work with school avoidance cases involves four

facets: assessment, consultation with parents, consultation with teachers, and counseling with students and their families. Understanding school avoidance from the perspective of the type of motivational ideas discussed above profoundly influences the approach to each of these tasks. The following examples are illustrative.

Corrective Interventions. In general, motivationally-oriented analyses of school avoidance allow interveners to offer parents, teachers, and the student an intervention responsive to the motivational underpinnings of school avoidance behavior. For instance, based on motivational data, parents and teachers can be helped to facilitate environment and program changes that account for a youngster's need to feel self-determining, competent, and related. Such changes may include (a) identifying activity options to attract a proactive school avoider, b) eliminating situations leading to reactive avoidance, and (c) establishing alternative ways for a student to cope with circumstances that cannot be changed. In counseling students, first focus on the individual's underlying motivation for avoidance (e.g., factors instigating, energizing, directing, and maintaining the motivation), explore motivation for change, clarify available alternatives with the student and significant others, and then facilitate action. It should be stressed that a motivational orientation does not supplant a focus on skill development and remediation. Rather, it places skill instruction in a motivational context and highlights the importance of systematically addressing motivational considerations in order to maximize skill development.

More specifically, the intervention focus for students behaving reactively, includes reducing reactance and enhancing positive motivation for attending school. That is, the fundamental enabling (process) objectives are (1) minimizing external demands for performing and conforming (e.g., eliminating threats) and (2) exploring with the student ways to add activities that would be nonthreatening and interesting (e.g., establishing program the majority of which emphasizes intrinsically motivating activities). For example, if Joe is concerned about a inability to handle assignments, steps are taken to match assignments to his current capabilities and provide help that minimizes failure and remedies deficits handicapping progress. If the problem stems from lack of interest in the current school program, the focus is on increasing the attractiveness of school by finding or creating new activities and special roles. If the avoidance truly is a phobic reaction, ongoing family counseling is indicated, as is extensive school consultation in pursuit of the type of expanded accommodation and support the student needs.

For youngsters whose avoidance is proactively motivated, staying home to watch TV or to hang out with friends, running around with gangs, and participating in the drug culture can be much more interesting and exciting than usual school offerings. This probably accounts for why proactive school avoidance can be so difficult to counter. Fundamentally, the objectives in trying to counter proactively motivated avoidance involve exploring and agreeing upon a program of intrinsically motivating activity to replace the student's current school program. The new program must be able to produce greater feelings of self-determination, competence, and relatedness than the activity that has pulled the youngster away from school. To these ends, alternatives must be nonthreatening and interesting and often will have to differ markedly from those commonly offered. For instance, such students may be most responsive to changes in program content that emphasize their contemporary culture (e.g., sports, rock music, movies and TV shows, computer games, auto mechanics, local events), processes that deemphasize formal schooling (e.g., peer tutoring, use of nonstandard materials), and opportunities to assume special, positive role status (e.g., as a student official, office monitor, paid cafeteria worker). Such personalized options and opportunities usually are essential starting points in overcoming proactive avoidance.

Starting or returning: the crucial transition phase. As avoiders are mobilized to start or return to school, it is critical to ensure the entry transition phase is positive. For instance, it is sometimes necessary to plan on only a partial school day schedule. This occurs when it is concluded that full day attendance would be counterproductive to enhancing intrinsic motivation for school.

It also is critical not to undermine a new or returning student's emerging hope about feeling

accepted, in control, and competent at school. Such students tend to be skeptical and fearful about whether they will fit in and be accepted. Often their worst fears come true. Two system characteristics commonly found to work against successful entry for school avoiders are (1) lack of a receptive atmosphere and (2) lack of special accommodation.

It seems obvious that school avoiders need to feel welcomed when enrolling in or returning to school. Yet, students and parents often report negative encounters in dealing with attendance office procedures, personnel who are unaware of the problem and special entry plans, and students and staff who appear hostile to the plans that have been made.

To counter such negative experiences, a key strategy is to arrange for one or more on-site advocates who increase the likelihood of a welcoming atmosphere by greeting the student and guiding her or him through the transition phase. One such advocate needs to be a professional on the school staff who will provide procedural help (with attendance and new schedules) and who can sensitize key personnel and students to the importance of a positive reception. A student advocate or peer counselor also is desirable if an appropriate one can be found.

It also must be recognized that many proactive and reactive avoiders, upon first entering or returning to school, do not readily fit in. This is especially true of those whose pattern of deviant and devious behavior contributed to school avoidance in the first place. For such students, teachers must not only be willing to offer attractive and nonthreatening program alternatives, they must be willing temporarily to structure wider limits than most students typically are allowed.

This section was adapted from School Avoidance Behavior: Motivational Bases and Implications for Intervention. Taylor & Adelman, 1989. Published in *Child Psychiatry and Human Development*, Vol. 20(4), Summer 1990.

"The third-grade crisis . . . day 53. . . ."

V. A Few Resource Aids

A. A Few More Fact Sheets
   - ➥School Phobia/School Avoidance/School Refusal
   - ➥Fears and Phobias
   - ➥The Role of Therapy in Effective Treatment
   - ➥Anxiety Disorders
   - ➥School Phobias Hold Many Children Back

B. ERIC Digest

C. A Few More Resources

From *Communique*: Special Edition-Page 8
National Association of School Psychologists-Summer 1998

School Phobia/School Avoidance/School Refusal

A Handout for Parents

by Leslie Z. Paige, Ed.S., NCSP
Hays West Central (KS)
Special Education Cooperative

Background

School phobia/school avoidance/school refusal are terms used to describe children who have a pattern of avoiding or refusing to attend school. Different from truancy, these behaviors occur in approximately 2% of school aged children. Historically called "school phobia", many researchers now prefer to use the terms "school avoidance" or "school refusal". There is confusion regarding the terms because children who experience significant difficulty in attending school do so for different reasons and exhibit different behaviors. In general, children who refuse to attend or avoid school stay in close contact with their parents or care givers, and are frequently (although not always) anxious and fearful. They may become very upset or become ill when forced to go to school. Truants may be distinguished from this group by their antisocial or delinquent behaviors, their lack of anxiety about missing school, and the fact that they are not in contact with parents or caregivers when they are avoiding school.

Development

Part of the confusion regarding the term "school phobia" is that the behaviors are not usually considered to be a true phobia. Although some children fear school-related activities (bus ride, reading aloud in class, changing for physical education), some are anxious about home issues or about being separated from a care giver. Children become anxious for many reasons. "Separation anxiety" typically occurs at about the age of 18 to 24 months. Toddlers will cry, cling and have temper tantrums when they are about to be separated from their care giver (for daycare or a babysitter, for example). This is normal at this age, but some older children continue to have difficulty separating from caregivers.

Sometimes school-aged children who were previously able to separate from their caregivers will suddenly become anxious and fearful. A recent crisis in the community or the family (such as a death, divorce, financial problems, move, etc.) may cause a child to become fearful or anxious. Some children fear that something terrible will happen at home while they are at school. Children who are struggling in school with academic or social problems may also develop school refusal. Many children have social concerns and may have been teased or bullied at school or on the way to school. Some neighborhoods or schools are unsafe or chaotic.

Children who have missed a lot of school due to illness or surgery may experience difficulty returning to the classroom routines as well as academic and social demands. Still other children prefer to stay home because they can watch tv, have parental attention, and play rather than work in school. Children and youth who are transitioning (from elementary to middle school, or middle school to high school) may feel very stressed. All of these factors may lead to the development of school refusal/avoidance. Additionally, many children avoid or refuse school for a combination of reasons, further complicating treatment.

If untreated, chronic school refusal or

avoidance may result in more than family distress. Academic deterioration, poor peer relationships, school or legal conflicts, work or college avoidance, panic attacks, agoraphobia and adult psychological or psychiatric disorders may result.

What Can Parents Do?
PREVENTION

Toddlers and preschoolers can benefit from structured experiences with other adults. Parents can help young children to separate from caregivers in several ways. Reliable and safe babysitting or daycare are excellent examples. Many communities have opportunities for preschoolers such as story hour at the library, preschool religious training such as bible school, recreational activities, preschool etc. When the child fusses at separation from the parent, the best strategy is to inform the child calmly that the parent will return and that the child is to stay. Then leave quickly. Children typically have more difficulty separating if their parents hover, linger, become upset, wait for the child to calm down or attempt to reason with the child . A firm, caring and quick separation is usually better for both parent and child. Preschool caregivers will typically report that the child's distress quickly disappears. However, children whose parents prolong the separation or who have had unsuccessful preschool separation experiences may need more time or support to calm down. This may be because they have learned that their distress results in parental rescue from separation! Successful preschool experiences ease the transition to preschool or kindergarten.

WHEN CHILDREN REFUSE OR AVOID SCHOOL

If complaints of illness are the excuse for not attending school, have the child checked by the family medical provider. If there is no medical reason to be absent, the child should be at school. The parent should attempt to discover if there is a specific problem causing the refusal. Sometimes the child feels relief just by expressing concerns about friends or school expectations. If the child is able to pinpoint a specific concern (such as worry about tests, teasing, etc.), then the parent should immediately talk to the child's teacher about developing an appropriate plan to solve the problem. Some common sense strategies to try include having another family member bring the child to school, or if the child does stay home then rewards such as snacking, tv, toys, or parental attention should be eliminated. A school schedule may be duplicated at home.

However, if the child is extremely upset, if the child needs to be forced to attend school, if there is significant family stress, or if the refusal to attend school is becoming habitual, the family should not hesitate in asking for assistance from the school psychologist, school counselor, or other mental health professionals. Parents and the school need to work together to identify what is causing or maintaining this behavior and to develop a comprehensive plan of intervention. A key to success is rapid intervention; the longer the behavior occurs, the harder it is to treat.

Treatment depends upon the causes, which can be difficult to determine. Many children may have started to avoid school for one reason (e.g., fear of being disciplined by a teacher, feeling socially inadequate) but are now staying home for another reason (e.g., access to video games, lack of academic pressure, etc.). Several treatment plans may need to be tried. Helping the child to relax, develop better coping skills, improve social skills, using a contract and helping the parents with parenting or family issues are all examples of possible treatments.

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Paige, L.Z. (1993). *The identification and treatment of school phobia.* Silver Spring, MD: National Association of School Psychologists.

NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS

Fears and Phobias

Bonnie Matthews
University of South Florida

Background

Fear has often been described by professionals and educators as a reaction to a threatening situation. For example, an individual may experience fear when being chased by a growling dog or by a bully approaching with clenched fists. Phobias have been described as "fears which are severe, persistent behavioral patterns of avoidance" (Kendall et al., 1991). According to the *Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised* (DSM-III-R; 1987), the most common phobias involve animals, particularly dogs, snakes, insects, and mice. Other common phobias include witnessing blood or tissue injury, closed spaces, and heights. When an individual is presented, in any way, with the phobic stimulus, he/she exhibits signs of anxiety. The phobic response may be elicited by nothing more, in some individuals, than the thought of the stimulus (i.e., imagining being near a dog or being in a high place).

Fears and phobias have been documented in individuals of all ages. Regarding children, Kratochwill, Sanders, and Wiemer (1991) report that the number of fears and phobias appears to vary with the age of the child. From their review of recent research results, they report that the number of fears tends to fluctuate from four to more than seven and that severe fears tend to be experienced by a fairly large proportion of children and adolescents. As a result of much research conducted on fears and phobias, effective treatments have become available. The review by Kratochwill and his colleagues (1987) indicates the following about fears associated with different aged children. Children aged 2 through 6 tend to have fears that are less reality based than those of other children of ages. For example, they tend to be afraid of things like ghosts and monsters. Children aged 7 through 12 tend to have fears that reflect threatening situations that seem more realistic. For example, they tend to be afraid of things like bodily injury and natural disasters. Children aged 13 through 18 tend to exhibit political fears as well as fears about personal-social relationships and fears of physical injury.

The Causes of Fears and Phobias

There are many theories about the potential causes of fears and phobias but the major characteristic of fears and phobias in children is that the child feels threatened by some situation. Phobic responses go one step further in that the fear about the situation is so severe that it interferes with their lives and the lives of those around them. Additionally, the fear may be to an unrealistic degree. Fears become problematic when they become so intense that the child's personal-social and/or school functioning begins to be negatively affected.

What Can I Do As A Parent?

In determining if fears are present and if the problem warrants further attention, you as a parent can consider the following questions.

—Are the behaviors associated with the fears typical for my child's age?

—What are the symptoms of the fear and how do they affect my child's personal, social, and academic functioning?

—Does the fear seem more severe than the situation would seem to warrant?

—Is the fear only a sign of a more serious problem that my child is experiencing?

—Is my child's behavior essentially normal, but people around him/her are finding it difficult to tolerate the behavior?

Suggestions for parents:

—Do not discount the emotional response of your child. His/her feelings may be very real to him /her.

—Listen to your child. Often times the fear may be decreased by providing the child with correct or specific information about the feared situation.

—Allow the child to discuss the fear with you. The child needs to know he/she has your understanding and support.

—Seek professional help if the fear seems to be interfering with your child's daily functioning or if it persists for a longer period of time than seems appropriate.

Resources

If further information is desired, you may find it helpful to consult with the school guidance counselor or school psychologist. Additionally, your local mental health centers, pediatricians, and clergy may be of assistance in providing you with information more specific to your child's needs.

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just the facts.

ANSWERS TO YOUR QUESTIONS ABOUT MENTAL HEALTH

Anxiety Disorders:

The Role of Therapy in Effective Treatment

Everyone feels anxious and under stress from time to time. Situations such as meeting tight deadlines, important social obligations or driving in heavy traffic, often bring about anxious feelings. Such mild anxiety may help make you alert and focused on facing threatening or challenging circumstances. On the other hand, anxiety disorders cause severe distress over a period of time and disrupt the lives of individuals suffering from them. The frequency and intensity of anxiety involved in these disorders is often debilitating. But fortunately, with proper and effective treatment, people suffering from anxiety disorders can lead normal lives.

What are the major kinds of anxiety disorders?

There are several major types of anxiety disorders, each with its own characteristics.

- People with **generalized anxiety disorder** have recurring fears or worries, such as about health or finances, and they often have a persistent sense that something bad is just about to happen. The reason for the intense feelings of anxiety may be difficult to identify. But the fears and worries are very real and often keep individuals from concentrating on daily tasks.
- **Panic disorder** involves sudden, intense and unprovoked feelings of terror and dread. People who suffer from this disorder generally develop strong fears about when and where their next panic attack will occur, and they often restrict their activities as a result.
- A related disorder involves **phobias**, or intense fears, about certain objects or situations. Specific phobias may involve things such as encountering certain animals or flying in airplanes, whereas social phobias involve fear of social settings or public places.
- **Obsessive-compulsive disorder** is characterized by persistent, uncontrollable and unwanted feelings or thoughts (obsessions) and routines or rituals in whichindividuals engage to try to prevent or rid themselves of these thoughts (compulsions). Examples of common compulsions include washing hands or cleaning house excessively for fear of germs, or checking over something repeatedly for errors.
- Someone who suffers severe physical or emotional trauma such as from a natural disaster or serious accident or crime may experience **post-traumatic stress disorder**. Thoughts, feelings and behavior patterns become seriously affected by reminders of the event, sometimes months or even years after the traumatic experience.

Symptoms such as shortness of breath, racing heartbeat, trembling and dizziness often accompany certain anxiety disorders such as panic and generalized anxiety disorders. Although they may begin at any time, anxiety disorders often surface in adolescence or early adulthood. There is some evidence of a genetic or family predisposition to certain anxiety disorders.

Why is it important to seek treatment for these disorders?

If left untreated, anxiety disorders can have severe consequences. For example, some people who suffer from recurring panic attacks avoid at all costs putting themselves in a situation that they fear may trigger an attack. Such avoidance behavior may create problems by conflicting with job requirements, family obligations or other basic activities of daily living.

(Over)

A Publication of the American Psychological Association Practice Directorate

Many people who suffer from an untreated anxiety disorder are prone to other psychological disorders, such as depression, and they have a greater tendency to abuse alcohol and other drugs. Their relationships with family members, friends and coworkers may become very strained. And their job performance may falter.

Are there effective treatments available for anxiety disorders?

Absolutely. Most cases of anxiety disorder can be treated successfully by appropriately trained health and mental health care professionals.

According to the National Institute of Mental Health, research has demonstrated that both "behavioral therapy" and "cognitive therapy" can be highly effective in treating anxiety disorders. Behavioral therapy involves using techniques to reduce or stop the undesired behavior associated with these disorders. For example, one approach involves training patients in relaxation and deep breathing techniques to counteract the agitation and hyperventilation (rapid, shallow breathing) that accompany certain anxiety disorders.

Through cognitive therapy, patients learn to understand how their thoughts contribute to the symptoms of anxiety disorders, and how to change those thought patterns to reduce the likelihood of occurrence and the intensity of reaction. The patient's increased cognitive awareness is often combined with behavioral techniques to help the individual gradually confront and tolerate fearful situations in a controlled, safe environment.

Proper and effective medications may have a role in treatment along with psychotherapy. In cases where medications are used, the patient's care may be managed collaboratively by a therapist and physician. It is important for patients to realize that there are side effects to any drugs, which must be monitored closely by the prescribing physician.

How can a qualified therapist help someone suffering from an anxiety disorder?

Licensed professional mental health providers such as psychologists are highly qualified to diagnose and treat anxiety disorders. Individuals suffering from these disorders should seek a provider who is highly competent in cognitive and behavioral therapies. Experienced mental health professionals have the added benefit of having helped other patients recover from anxiety disorders.

Group therapy offers a helpful approach to treatment for some patients. In addition, mental health clinics or other specialized treatment programs dealing with specific disorders such as panic or phobias may also be available nearby.

How long does psychological treatment take?

It is very important to understand that treatments for anxiety disorders do not work instantly. The patient should be comfortable from the outset with the general treatment being proposed and with the therapist with whom he or she is working. The patient's cooperation is crucial, and there must be a strong sense that the patient and therapist are collaborating as a team to remedy the anxiety disorder.

No one plan works well for all patients. Treatment needs to be tailored to the needs of the patient and to the type of disorder, or disorders, from which the individual suffers. A therapist and patient should work together to assess whether a treatment plan seems to be on track. Adjustments to the plan sometimes are necessary, since patients respond differently to treatment.

Many patients will begin to improve noticeably within eight to ten sessions, especially those who carefully follow the outlined treatment plan.

There is no question that the various kinds of anxiety disorders can severely impair a person's functioning in work, family and social environments. But the prospects for long-term recovery for most individuals who seek appropriate professional help are very good. Those who suffer from anxiety disorders can work with a qualified and experienced therapist to help them regain control of their feelings and thoughts -- and their lives.

American Psychological Association

Practice Directorate
750 First Street, NE
Washington, DC 20002-4242
202/336-5800

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ANXIETY DISORDERS

Description/Symptoms/Diagnosis

Anxiety is a universal emotion that every person regularly experiences. When a person has excessive anxiety that interferes with normal performance or health, however, he or she may have an anxiety disorder. There are many different types of anxiety disorders with symptoms that range from a fear of a specific situation or object to more generalized but constant feelings of apprehension or unease. Most people with anxiety disorders experience an overwhelming sense of fear that generally incapacitates them for a period of time. Physiological responses, such as increased heart rate, breathing, and muscular tension frequently occur. Different types of anxiety disorders often co-occur in the same individual and depression is commonly associated with excessive anxiety.

Many anxiety disorders that are common in adults may also be seen in children. These include phobic disorders, post-traumatic stress disorder, obsessive compulsive disorder, panic disorder, and generalized anxiety disorder. Separation anxiety disorder is a disorder only found in children.

Separation Anxiety Disorder--A child with this disorder becomes anxious when separated from familiar persons or territory. Anticipated separation may cause the child to complain of physical illness and, after separation occurs, the child may be inconsolable and fearful that a loved one may not return or may be prevented from reuniting with the child due to some terrible tragedy. Onset of symptoms are usually reported during preschool years and the most extreme form of the disorder is reported in prepubertal children, who may refuse to go to school to avoid being separated from their loved one. Symptoms may include unrealistic worry, avoidance of being alone in the home, reluctance to go to school, physical symptoms (e.g., stomachaches, headaches, nausea, vomiting) on school days, social withdrawal, apathy, sadness, or difficulty concentrating on work or play when not with a major attachment figure.

Causation/Incidence

Some professionals believe that there is a strong hereditary-biological component to anxiety disorders, while others believe childhood anxiety to be a learned response. There are a variety of factors that may contribute to the development of anxiety disorders in children. These include a history of anxiety disorders in a family, stressful life events, developmental factors, neurological factors, drug reactions, and a child's temperament. It is possible that problems with the brain's chemical neurotransmitter system contribute to the development of anxiety disorders, but the potential causes of hereditary versus environmental factors is still being explored.

From 10 to 40 percent of school age children are affected by specific fears common in childhood, but in most cases, these fears cause little difficulty and disappear with time. It has been estimated that between 1 and 3 percent of children and adolescents suffer from true anxiety disorders. Most children with anxiety disorders do not have anxiety disorders as adults.

Treatment

Both behavioral and pharmacological interventions have been used successfully to treat anxiety disorders in children and adolescents. Some behavioral treatments involve step-by-step desensitizing or exposing a child to the feared situation or object. In others, a child with an anxiety disorder observes another child modeling adaptive behavior in response to the feared situation or object. These treatments attempt to change children's subjective and physiological reactions to what they fear. Psychotherapy and group skills training have also been used to treat children with anxiety disorders.

Various psychotropic medications have been found to be generally effective in treating children and adolescents with anxiety disorders. The precise means by which these medications work is unknown, but they are thought to affect the

brain's chemical neurotransmitter system.

Role of Family/Impact on Family

Life with a child who has a serious emotional disorder may be associated with a number of troubling and conflicting feelings: love, anger, anxiety, grief, guilt, fear, and depression. These feelings are not unusual; most parents find it is helpful to share these feelings with someone else--family, friends, a support group, or some other informal group. Parents need to realize the scope and limitations of their responsibility and learn to take care of themselves as well as their child. Professional help in the form of individual, couples, or family counseling may be helpful in providing emotional support and guidance and help in the child's recovery.

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Other Resources

Anxiety Disorders Association of America
6000 Executive Blvd. #200
Rockville, Maryland 20852-3883
(301) 231-9350
Promotes welfare of people with phobias and related anxiety disorders. An organization for consumers, health care professionals & other concerned individuals.

Council on Anxiety Disorders
P.O. Box 17011
Winston-Salem, North Carolina 27116
(919) 722-7760
Offers education, advocacy, and mutual support for people with anxiety disorders: general anxiety, panic disorders, phobias, obsessive compulsive disorders, post-traumatic stress syndrome.

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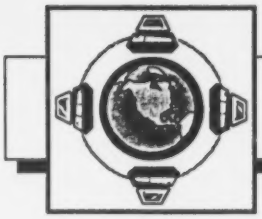

From the APA Monitor
http://www.apa.org/monitor/sep97/fear.html

School phobias hold many children back

It takes a team effort to help children overcome fear of school.

By Bridget Murray
Monitor staff

As millions of school children head back to school this month, many eagerly await reuniting with friends and starting new academic challenges. But others bemoan leaving the comfort of home for the trials of school—a place where they might wear the wrong clothes or give the wrong answer in class. Some even refuse to go, throwing tantrums or complaining of stomachaches, headaches or nausea.

These children suffer from what's commonly known as school phobia, although many psychologists prefer calling it school refusal (see sidebar about the definition dispute). Affecting between 5 percent and 10 percent of U.S. school children in its mildest form—and 1 percent of them in its severest form—the phobia can lead to serious problems with school absenteeism, psychologists say.

Chronic absence puts students at risk for psychological problems later in life, such as alcohol abuse and criminal behavior, as well as underemployment and even marital difficulties, says psychologist Christopher Kearney, PhD, a school refusal researcher at the University of Nevada, Las Vegas.

Broadly defined, school phobia is anxiety and fear related to being in school. In addition to throwing tantrums and feigning sickness, other typical school-refusal behaviors include panic attacks, crying, shyness, unhappiness, demands for parental attention, petulance and clinginess, psychologists report.

Most often the problems emerge after children have had long breaks from school, says Kearney. As their vacation dwindles to an end, some children dread the return to peers, teachers and homework. They may feel safer in the sanctity of home, where they feel loved by their parents instead of judged by their peers and teachers, psychologists say.

A closer look at the problem reveals that some children experience "generalized" anxiety about their abilities. They fear softball games, quizzes, science projects—anything that tests their mettle. Other children have distinct types of anxiety-related school refusal, says Kearney. One type stems from childhood anxiety about separating from mother and family. Another type—social phobia—involves worry over peer relations or public speaking. And simple phobias are fears about specific aspects of school, such as the wail of the fire-alarm or the walk down the hallway between classes. Several warning signs can alert teachers that a child is school phobic, says psychologist Robert Deluty, PhD, director of clinical training at the University of Maryland–Baltimore County. These include crying fits in class, withdrawn behavior and excessive time spent in the nurse's office. Teachers play a crucial role in flagging the problem and consulting parents and psychologists about treatment, notes Deluty.

Overcoming the problem requires a team effort involving teachers, parents and psychologists, he says.

Separation anxiety

Separation anxiety typically affects young children. Those afflicted worry excessively when separated from their home and parents, often fearing for their life or their parents' lives, says Deluty. They worry that their parents will be kidnapped, attacked by monsters or killed in a car accident. To allay their worries, they cling to adults and demand constant attention.

Children with the problem experience such high levels of anxiety that their muscles tense up and their stomachs ache—they feel too ill to attend school but doctors find no evidence of physical illness, says Deluty.

Causes of separation anxiety are hard to pinpoint, but anxiety-prone children and depressive children with low self confidence are particularly susceptible, researchers say. The same is true of phobic children, they note. In many cases, parents unwittingly reinforce the problem by catering to their children's every whim, coddling and pampering them instead of encouraging them to think independently and solve their own problems, says Achenbach. Often the parent—in many cases the mother-becomes dependent on the child's company as well, Achenbach says.

In fact, mothers of anxious children often themselves have histories of school refusal, found psychologist Cynthia Last, PhD, director of the School Phobia program at Nova Southeastern University in Fort Lauderdale, Fla., in a study of 145 anxious children and adolescents. The study was published in 1990 in the Journal of the American Academy of Child and Adolescent Psychiatry (Vol. 29, No. 1, p. 31–35). Unhealthy cycles of dependency tend to run in families, she says.

Illustrating this phenomenon is the case of a 6-year-old school-phobic boy, treated by psychologist Larazo Garcia, PhD, of the Miami Psychological and Behavioral Center. The boy and his mother spent their days together "like one unit," says Garcia. The boy balked at attending school, and his mother, who was single and on welfare, didn't make him go.

Garcia used desensitization, a common anxiety treatment, to conquer the boy's fear of mother separation. He first introduced the boy to play with neighborhood children, then brought the boy to school and sat in class with him for 10 minutes.

On subsequent days he increased the time they spent together in school to gradually ease that child into a daily school routine. Noting that regular, extended separations from his mother hurt neither him nor her, the boy learned to spend his days at school. Anxious children typically spend too little time at school to realize that their parents are safe without them, Garcia notes. Garcia also involved the school's staff, a crucial aspect of treatment, says Kearney. Teachers and school nurses can encourage children to stay in class and urge them to check their anxiety by talking through it or using breathing exercises to calm their rapid breathing. Calling their parents should be the last resort, he says.

For their part, parents can more firmly set and enact rules about school attendance. Creating a regular morning routine prevents children from dwelling on anxiety and developing school-related aches and pains, says Kearney. Psychotherapy can also be used to help children face their fears, including the use of dolls to help them act out unrealistic fears about their parents getting injured or sick.

Social and simple phobias

Garcia's young patient also had an acute fear of interacting with peers and unknown adults, a form of social phobia. The child was extremely

obese, which made him feel like a misfit.

"Some children are extremely fearful of being humiliated or embarrassed," says Last. 'Peers' opinions are everything to them and children obsess over how others judge them."

In fact, most social phobias begin at around ages 11 or 12, a time when children tend to most viciously insult and pick on each other.

This cruelty, Last says, can seriously harm sensitive children. Particularly at-risk for developing peer-related phobias are children harassed for physical traits, such as obesity, skinniness or physical disabilities. Inteilectual ability is also a source of heckling from peers: Some children suffer for their braininess while others get teased for their academic slowness, Last notes.

Adding to the problem of peer-related phobias is an increasingly hostile school environment, adds Cynthia Pilkington, PhD, a child and school psychologist at the Central Plains Clinic in Sioux Falls, S.D. Her patients experience aggression and name-calling at increasingly younger ages. "It used to be that nastiness was mostly in middle schools, but the teasing and taunting starts in kindergarten these days," says Pilkington.

Children with performance-related phobias may fear public speaking, tests or being questioned by teachers in class. Some develop unreasonable fears about their grades and academic performance, becoming so paralyzed with fear that they can't perform at all. Most of these children are perfectionists who fear earning a "B," Last says.

A number of treatments are available for the various phobias. As with separation anxiety, desensitization helps children grow accustomed to peers and eases them into the academic cycle of testing and grading. Some treatments focused on increasing competence are relatively straightforward, Deluty adds. For example, the child who fears public speaking will likely benefit from help giving speeches and the child who fears failing math class may simply need extra math tutoring, he says.

Also beneficial is coping-skills training that helps children avert or counter bullying remarks. The training teaches children to respond to insults with a firm voice and direct eye contact, instead of with violence or passive weeping, says Deluty. Teachers can also help by giving phobic students "a way to shine," says Pilkington. Such tasks as decorating a class bulletin board give anxious children a positive sense of identity, she says.

Drug treatments are also available to treat school phobia. Some psychiatrists have been using imipramine, which has antipanic and antidepressive effects. Thus far, though, studies of the drug's effects are inconclusive.

It's hard to tell what treatment works best because school phobia is an under-researched area, says Last. Behavioral therapy shows promise, but even those results are based largely on case studies, she says. However, notes Last, one thing is certain. With dogged cooperation from parents and school staff, most school phobias can be conquered.

ERIC DIGEST

ERIC Digests are brief research syntheses available at libraries, over the Internet or by contacting ERIC. For more information about ERIC and ERIC Digests, see the Selected References and Internet sections of this introductory packet.

CHILDREN AND FEARS

Children's fears can have a self-preserving and motivational quality or have an inhibiting or debilitating effect. According to Morris & Kratochwill (1983) 4% to 8% of all children in the United States will receive clinical treatment for fear-related disorders. The numbers of untreated population often run as much as two times those of the treated population. In a recent survey of teachers in American international schools, the vast majority of teachers believed that children were adversely affected by fears and that as many as 50% were not functioning effectively at some time because of fear-related concerns (Robinson, Rotter, Fey, & Robinson, 1991).

ENVIRONMENT VS. HEREDITY

The controversy of heredity versus environment is always an issue in examining the development of attributes in children. Kagan (1986) has been engaged in a longitudinal study of children from birth to age 8. His findings suggest that children may have some inherent predisposition toward fearfulness. Some children are much more prone to fearful behaviors from birth than other children. He also noted that over a period of 8 years some children who were more fearful at birth became less so and some who were less fearful became more so. This suggests that, although there may be a hereditary link involved in the development of fear, environmental factors also play a large part in the development of children's fears. Although Kagan's research suggests that some children will be prone to react more to fear objects, it is generally agreed that all children will exhibit fears and, while many are transitory in nature, the fears appear at about the same age for most children (Morris & Kratochwill, 1983; Robinson, Robinson, Whetsell, & Weber, 1988).

FEAR CYCLE

Fear is the anticipation of or awareness of exposure to injury, pain, or loss. A fear object, then, is any object or conceptualization that the child anticipates might cause injury, pain, or loss. The degree of fear is related to the child's perception of vulnerability. In the fear cycle, the child perceives an object or concept, which is compared with one's sense of self and one's personal resources. The child may experience this with a sense of power and a feeling of

confidence (affect); the child may realize that he or she has the resources to deal effectively with the source of potential threat (cognition); the child may get butterflies (physiological response); and then the child may take some action (behavioral response). As a result of the action, the child again examines the potential threat of the fear object. The degree to which the child's action lessens the potential threat influences the child's perception of the fear object. The more children successfully handle such situations, the less vulnerable they may feel. Conversely, the less successful they are, the more vulnerable children may feel. Vulnerable children may express more concerns about an array of fear objects and may generally approach new situations with greater trepidation. Some children may be generally successful but maintain "unreasonable fears" with regard to a particular fear object.

FOUNDATIONS OF SUCCESSFUL COPING

Children who have confidence in their ability to master and control events and challenges in their lives are less vulnerable to fear. These children have a sense of personal power. In contrast, a child who feels helpless in the face of danger is vulnerable to fears. Related to power are these three important constructs:

Self-worth. Children who feel good about themselves, hold themselves in high esteem, and experience success in meeting normal developmental tasks have well developed concepts of self-worth. Based on this success identity, they are more likely to have the confidence needed to explore and attempt new strategies to overcome fears.

Security. Children who have adults in their lives who care for and encourage them develop a sense of security. Because they have allies on whom they can count, they are able to build supportive interpersonal relationships with peers and adults.

Control. Children who have been given some autonomy in decision making learn they have a degree of control over their lives. They learn to assess their strengths and weaknesses and accept that coping with dilemmas in life is a natural part of growing up.

TERRORS

Children can be adversely affected by disasters and terrors (Figley & McChubbin, 1983; Terr, 1981; Trautman, 1987). A traumatic event in a child's life can lead to fear-related problems that interfere with the child's normal functioning. A child who otherwise is functioning on a high level with regard to the concepts of control, self-worth, and security may develop reactions to specific fear objects in this way.

EFFICACY OF CURRENT APPROACHES

Counselors approach work with children on issues of stress anxiety and fear from the particular theoretical background to which they might adhere. The literature suggests that both insight and behavioral approaches can work with some children (Miller, Barrett, Hampe, & Noble, 1972). However, each approach does not seem to work with all children. This suggests that while effective, each of the current approaches to counseling children regarding their fears has some limitations.

Since the development of counseling models has not yet reached the point of explaining all phenomenon it is important that we continue to develop more comprehension models and organize intervention strategies into a systematic approach that can be effective with a broad range of children under varying circumstances.

COUNSELOR STRATEGIES

Counselors need a multifaceted delivery system that integrates strategies along a continuum for primary prevention of disturbances related to fear and anxiety. The model suggested here posts three levels of intervention. The first level focuses on developmental guidance and counseling activities designed for all children to develop a sense of control, security and self-worth. Also provided are ctivities that help children's exploration of normative childhood fears in order to "gauge it to the power of proper reaction" (Hall, 1897).

The second level of prevention should focus on higher risk children. Children who have been exposed to traumatic events in life are more susceptible to developing fear-related problems. Such events can be collective, such as Hurricane Hugo in South Carolina in 1989 or the San Francisco earthquake of the same year, or they can be of more limited scope affecting several children or just one.

Finally, those children who are experiencing fear disturbances are the target of the third level of intervention. The time to prevent the downward cycle is when the child is first experiencing a lack of effective coping regarding fear and anxiety.

1. Developmental Interventions

The goal of developmental intervention is to assist all children in making successful transitions in meeting life's challenges in the present and to build skills, knowledge and awareness to be successful in the future. In this case it means helping children develop successful strategies in coping with normative aspects of fear and stress and promoting the child's sense of control, security and self-worth that generally lead to successful coping.

Knowing information about normative fears in childhood allows the counselor to design activities that help children explore these fears and to develop an understanding of coping strategies for meeting their needs in dealing with them.

The second developmental approach is one many school counselors may already be using, working to help children develop a better sense of control over the life course by providing activities on decision making, helping children develop a sense of their strengths through success experiences and increasing a sense of self-worth by providing activities that stress interpersonal skills.

2. High-Risk Children

Children who have experienced personal terrors or disasters or are experiencing a high level of stress are more likely to develop coping problems related to fears and stress. Individual instances related to moving, changing schools, failure, loss of a close relative, divorce, or bodily injury often place children in a vulnerable position in life. Disasters such as earthquakes, hurricanes, or acts of violence such as mass shootings or war affect large numbers of children at the same time. In such situations the counselor

will wish to target these children, parents, teachers for special intervention. Group counseling activities that help children explore self in relationship to their life events are most appropriate. Consultation with parents and teachers on the signs of post traumatic stress symptoms and activities they can do to help children put such events into perspective is another important intervention strategy for high-risk children.

3. Fear-Related Problems

Helping children who are experiencing an inability to cope constitutes the third level of prevention. A summary of the research indicates that children who are helped as soon as possible regarding fear-related problems are most likely to develop ways to overcome those difficulties (Robinson, Rotter, Fey, & Robinson, 1991). When fear-related problems do surface early intervention prevents more severe problems.

In counseling the fearful child the first stage should be devoted to providing a cathartic release for the child, validating the child's fear (the child's fears, no matter how mystical or imaginary, are real to the child) and establishing a relationship characterized by trust and open communication.

The second stage deals with assessing the child's relationship with the fear. Does it seem that the child's difficulty focuses specifically on one fear object or multiple objects? Does the fear seem to be situationally specific or more generalized? Does the child seem to have a strong or weak sense of control, security, self-worth?

In stage three the counselor may choose systematic desensitization, cognitive restructuring, cognitive self-control, relaxation training or a combination. Or the counselor might choose a life skills training approach.

The final and fourth stage is evaluation. How well do the strategies employed help the child improve?

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The content of this digest was developed by Edward H. Robinson III, Ph.D, a professor in the Deparment of Educational Psychology

at the University of South Carolina in Columbia; Joseph C. Rotter, Ph.D, a professor and chairperson in the Department of Educational Psychology at the University of South Carolina in Columbia.

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NIH CONSENSUS STATEMENT: TREATMENT OF PANIC DISORDER

In September 1991, the Office of Medical Applications of Research of the National Institutions of Health in conjunction with the National Institute of Mental Health sponsored the "NIH Consensus Development Conference on Treatment of Panic Disorder". A consensus panel comprising of experts in the medical and psychiatric field, as well as members of the general public, formulated a consensus statement that addressed the following five questions:

- What are the epidemiology, natural history, and course of panic disorder with and without agoraphobia? How is it diagnosed?
- What are the current treatments? What are the short term and long term effects of acute and extended treatment of this disorder?
- What are the short-term and long-term adverse effects of these treatments? How should they be managed?
- What are considerations for treatment planning?
- What are the significant questions for future research?

The full text of the statement can be accessed at http://odp.od.nih.gov/consensus/cons/085/085_statement.htm

Conclusions and Recommendations

- Panic disorder is a distinct condition with a specific presentation, course, and positive family history and for which there are effective pharmacologic and cognitive-behavioral treatments.
- Treatment that fails to produce benefit within 6-8 weeks should be reassessed. Patients with panic disorder often have one or more comorbid conditions that require careful assessment and treatment.
- The most critical research needs are:
  a. the development of reliable, valid, and standard measures of assessment and outcome;
  b. the identification of optimal choices and structuring of treatments designed to meet the varying individual needs of patients; and
  c. the implementation of basic research to define the nature of the disorder.

Barriers to treatment include awareness, accessibility, and affordability.

- An aggressive educational campaign to increase awareness of these issues should be mounted for clinicians, patients and their families, the media, and the general public.

http://www.psychguides.com/eks_oche.htm

Expert Consensus Treatment Guidelines for Obsessive-Compulsive Disorder: A Guide for Patients and Families

...In the United States, 1 in 50 adults currently has OCD, and twice that many have had it at some point in their lives...

WHAT IS OBSESSIVE-COMPULSIVE DISORDER?

...it is as though the brain gets stuck on a particular thought or urge and just can't let go. People with OCD often say the symptoms feel like a case of mental hiccups that won't go away. OCD is a medical brain disorder that causes problems in information processing....

...OCD can start at any time from preschool age to adulthood (usually by age 40). One-third to one-half of adults with OCD report that it started during childhood. ...

What are the symptoms of obsessive-compulsive disorder?
...OCD usually involves having both obsessions and compulsions, though a person with OCD may sometimes have only one or the other. ...

WHAT OTHER PROBLEMS ARE SOMETIMES CONFUSED WITH OCD?

In children and adolescents, OCD may worsen or cause disruptive behaviors, exaggerate a pre-existing learning disorder, cause problems with attention and concentration, or interfere with learning at school. In many children with OCD, these disruptive behaviors are related to the OCD and will go away when the OCD is successfully treated.

For further information on the causes, genetic research, common obsessions and compulsions and other questions related to OCD please visit http://www.psychguides.com/eks_ocgl.htm. This site offers information for parents, families and professionals, including other resources for information.

Relevant Center Materials

UCLA Center for Mental Health in Schools

SOME SPECIAL RESOURCES FROM THE CLEARINGHOUSE

The mission of the Center is to improve outcomes for young people by enhancing policies, programs, and practices relevant to mental health in schools in schools.

Under the auspices of the School Mental Health Project in the Department of Psychology, our Center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. Specific attention is given to policies and strategies that can counter fragmentation and enhance collaboration between school and community programs.

A partial list...

I. Introductory Packets

Working Together: From School-Based Collaborative Teams to School-Community-Higher Education Connections

This packet discusses the processes and problems related to working together at school sites and in school-based centers. It also outlines models of collaborative school-based teams and interprofessional education programs*.

Violence Prevention and Safe Schools

This packet outlines selected violence prevention curricula and school programs and school-community partnerships for safe schools. It emphasizes both policy and practice.

Least Intervention Needed: Toward Appropriate Inclusion of Students with Special Needs

This packet highlights the principle of *least intervention needed* and its relationship to the concept of *least restrictive environment.* From this perspective, approaches for including students with disabilities in regular programs are described.

Parent and Home Involvement in Schools

This packet provides an overview of how home involvement is conceptualized and outlines current models and basic resources. Issues of special interest to under-served families are addressed.

Assessing to Address Barriers to Learning

This packet discusses basic principles, concepts, issues, and concerns related to assessment of various barriers to student learning. It also includes resource aids on procedures and instruments to measure psychosocial, as well as environmental barriers to learning.*

*You may download the indicated documents through our website at: http://smhp.psych.ucla.edu

Cultural Concerns in Addressing Barriers to Learning

This packet highlights concepts, issues and implications of multiculturalism/cultural competence in the delivery of educational and mental health services, as well as for staff development and system change. It also includes resource aids on how to better address cultural and racial diversity in serving children and adolescents.*

Dropout Prevention

This packet highlights intervention recommendations and model programs, as well as discusses the motivational underpinnings of the problem.*

Learning Problems and Learning Disabilities

This packet identifies learning disabilities as one highly circumscribed group of learning problems, and outlines approaches to address the full range of problems.*

Teen Pregnancy Prevention and Support

This packet covers model programs and resources and offers an overview framework for devising policy and practice.*

II. Resource Aid Packets

Screening/Assessing Students: Indicators and Tools

This packet is designed to provide some resources relevant to screening students experiencing problems. In particular, this packet includes a perspective for understanding the screening process and aids for initial problem identification and screening of several major psychosocial problems.*

Responding to Crisis at a School

This packet provides a set of guides and handouts for use in crisis planning and as aids for training staff to respond effectively. It contains materials to guide the organization and initial training of a school-based crisis team, as well as materials for use in ongoing training, and as information handouts for staff, students, and parents.*

Addressing Barriers to Learning: A Set of Surveys to Map What a School Has and What It Needs

This packet provides surveys covering six program areas and related system needs that constitute a comprehensive, integrated approach to addressing barriers and thus enabling learning. The six program areas are (1) classroom-focused enabling, (2) crisis assistance and prevention, (3) support for transitions, (4) home involvement in schooling, (S) student and family assistance programs and services, and (6) community outreach for involvement and support (including volunteers).*

Students and Psychotropic Medication: The School's Role

This packet underscores the need to work with prescribers in ways that safeguard the student and the school. It contains aids related to safeguards and for providing the student, family, and staff with appropriate information on the effects and monitoring of various psychopharmacological drugs used to treat child and adolescent psycho-behavioral problems.*

*You may download the indicated documents through our website at: http://smhp.psych.ucla.edu

Substance Abuse

This packet offers some guides to provide schools with basic information on widely abused drugs and indicators of substance abuse. It also includes some assessment tools and reference to prevention resources.*

Clearinghouse Catalogue

Our Clearinghouse contains a variety of resources relevant to the topic of mental health in schools. This annotated catalogue classifies these materials, protocols, aids, program descriptions, reports, abstracts of articles, information on other centers, etc. under three main categories: policy and system concerns, program and process concerns, and specific psychosocial problems. (Updated regularly)*

Catalogue of Internet Sites Relevant to Mental Health in Schools

This catalogue contains a compilation of Internet resources and links related to addressing barriers to student learning and mental health in schools. (Updated regularly)*

Organizations with Resources Relevant to Addressing Barriers to Learning: A Catalogue of Clearinghouses, Technical Assistance Centers, and Other Agencies

This catalogue categorizes and provides contact information on organizations focusing on children's mental health, education and schools, school-based and school-linked centers, and general concerns related to youth and other health related matters. (Updated regularly)*

Where to Get Resource Materials to Address Barriers to Learning

This resource offers school staff and parents a listing of centers, organizations, groups, and publishers that provide resource materials such as publications, brochures, fact sheets, audiovisual & multimedia tools on different mental health problems and issues in school settings.*

III. Technical Aid Packets

School-Based Client Consultation, Referral, and Management of Care

This aid discusses why it is important to approach student clients as consumers and to think in terms of managing *care*, not *cases*. It outlines processes related to problem identification, triage, assessment and client consultation, referral, and management of care. It also provides discussion of prereferral intervention and referral as a multifaceted intervention. It clarifies the nature of ongoing management of care and the necessity of establishing mechanisms to enhance systems of care. It also provides examples of tools to aid in all these processes ware included.*

School-Based Mutual Support Groups (For Parents, Staff; and Older Students)

This aid focuses on steps and-tasks related to establishing mutual support groups in a school setting. A sequential approach is described that involves (1) working within the school to get started, (2) recruiting members, (3) training them on how to run their own meetings, and (4) offering off-site consultation as requested. The specific focus here is on parents; however, the procedures are readily adaptable for use with others, such as older students and staff.*

*You may download the indicated documents through our website at: http://smhp.psych.ucla.edu

Volunteers to Help Teachers and School Address Barriers to Learning

This aid outlines (a) the diverse ways schools can think about using volunteers and discusses how volunteers can be trained to assist designated youngsters who need support, (b) steps for implementing volunteer programs in schools, (c) recruitment and training procedures and (d) key points to consider in evaluating volunteer programs. The packet also includes resource aids and model programs.*

Welcoming and Involving New Students and Families

This aid offers guidelines, strategies, and resource aids for planning, implementing, and evolving programs to enhance activities for welcoming and involving new students and families in schools. Programs include home involvement, social supports, and maintaining involvement.*

Guiding Parents in Helping Children Learn

This aid is specially designed for use by professionals who work with parents and other nonprofessionals, and consists of a "booklet" to help nonprofessionals understand what is involved in helping children learn. It also contains information about basic resources professionals can draw on to learn more about helping parents and other nonprofessionals enhance children's learning and performance. Finally, it includes additional resources such as guides and basic information parents can use to enhance children's learning outcomes.*

IV. Technical Assistance Samplers

Behavioral Initiatives in Broad Perspective

This sampler covers information on a variety of resources focusing on behavioral initiatives to address barriers to learning (e.g., state documents, behavior and school discipline, behavioral assessments, model programs on behavioral initiatives across the country, school wide programs, behavioral initiative assessment instruments, assessing resources for school-wide approaches).*

School-Based Health Centers (7/98)

This sampler includes information on a wide range of issues dealing with school-based health centers (e.g., general references, facts & statistics, funding, state & national documents, guides, reports, model programs across the country).*

V. Guides to Practice and Continuing Education Units -- Ideas into Practice

Mental Health and School-Based Health Centers

This revised guidebook is virtually a completely new aid. The introductory overview focuses on where the mental health facets of school-based health centers (SBHCs) fit into the work of schools. This is followed by three modules. Module I addresses problems related to limited center resources (e.g., limited finances) and how to maximize resource use and effectiveness); Module II focuses on matters related to working with students (consent, confidentiality, problem identification, prereferral interventions, screening/assessment, referral, counseling, prevention/mental health education, responding to crises, management of care); Module III explores quality improvement, evaluating outcomes, and getting credit for all you do. Each module is organized into a set of units with many resource aids (sample forms and special exhibits, questionnaires, interviews, screening indicators) for use as part of the day-by-day SBHC operational focus on mental health and psychosocial concerns. A coda highlights ways to and benefits of weaving together all resources for addressing barriers to student learning into a comprehensive, integrated approach.

*You may download the indicated documents through our website at: http://smhp.psych.ucla.edu

What Schools Can Do to Welcome and Meet the Needs of All Students and Families

This guidebook offers program ideas and resource aids that can help address some major barriers that interfere with student learning and performance. Much of the focus is on early-age interventions; some is on primary prevention; some is on addressing problems as soon after onset. The guidebook includes the following: Schools as Caring, Learning Environments, Welcoming and Social Support: Toward a Sense of Community Throughout the School; Using Volunteers to Assist in Addressing School Adjustment Needs and Other Barriers to Learning; Home Involvement in Schooling; Connecting a Student with the Right Help; Understanding and Responding to Learning Problems and Learning Disabilities; Response to Students' Ongoing Psychosocial and Mental Health Needs; Program Reporting: Getting Credit for All You Do and, Toward a Comprehensive, Integrated Enabling Component.

CONTINUING EDUCATION MODULES

Addressing Barriers to Learning: New Directions for Mental Health in Schools

This module consists of three units to assist mental health practitioners in addressing psychosocial and mental health problems seen as barriers to students' learning and performance. It includes procedures and guidelines on issues such as initial problem identification, screening/assessment, client consultation & referral, triage, initial and ongoing case monitoring, mental health education, psychosocial guidance, support, counseling, consent, and confidentiality.*

Mental Health in Schools: New Roles for School Nurses

The above three units have been adapted specifically for school nurses. A subset of the nursing material will appear in video/manual self-study format produced by National Association of School Nurses with support of the Robert Wood Johnson Foundation and National Education Association.*

Continuing Education Related to the Enabling Component

Classroom Focused Enabling

This module consists of guidelines, procedures, strategies, and tools designed to enhance classroom based efforts by increasing teacher effectiveness for preventing and managing problems in the classroom and helping address barriers to learning.

VI. Feature Articles from Our Newsletter*

Mental Health in Schools: Emerging Trends (Winter '96)

Presents an overview of the need to include a focus on mental health in schools as part of efforts to address barriers to student learning. Highlights emerging trends and implications for new roles for mental health professionals. Includes tables outlining the nature and scope of students' needs, the range of professionals involved, and the types of functions provided.

School-Linked Services and Beyond (Spring '96)

Discusses contributions of school-linked services and suggests it is time to think about more comprehensive models for promoting healthy development and addressing barriers to learning.

*You may download the indicated documents through our website at: http://smhp.psych.ucla.edu

Labeling Troubled and Troubling Youth: The Name Game (Summer '96)

Underscores bias inherent in current diagnostic classifications for children and adolescents and offers a broad framework for labeling problems so that transactions between person and environment are not downplayed. Implications for addressing the full range of problems are discussed.

Comprehensive Approaches & Mental Health in Schools (Winter '97)

Discusses the enabling component, a comprehensive, integrated approach that weaves six main areas into the fabric of the school to address barriers to learning and promote healthy development for *all* students.

Behavior Problems: What's a School to Do? (Spring '97)

Sheds light on the prevailing disciplinary practices in schools and their consequences for classroom management purposes. Beyond discipline and social skills training, the article underscores the need to look into the underlying motivational bases for students' misbehavior for intervention programs to take effect.

Enabling Learning in the Classroom: A Primary Mental Health Concern (Spring '98)

Highlights the importance of institutionalizing the *enabling component* in schools. Discusses how *classroom-focused enabling* (one of six clusters of programmatic activity) enhances the teacher's array of strategies for working with a wide range of individual differences (including learning and behavior problems) and creating a caring context for learning in the classroom.

*You may download the indicated documents through our website at: http://smhp.psych.ucla.edu

Note: A small fee is charged to cover copying, first class mailing, and handling for most items. See our clearinghouse's order form.

For further information, you can contact the center at:

Write: School Mental Health Project/Center for Mental Health in Schools, Box 951563, Department of Psychology, UCLA, Los Angeles, CA 90095-1563
Ph: (310) 825-3634 Fax: (310) 206-8716 E-mail: smhp@ucla.edu

Also try out our website: **http://smhp.psych.ucla.edu/**

The Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project, Dept. of Psychology, UCLA. Support comes in part from the Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health.

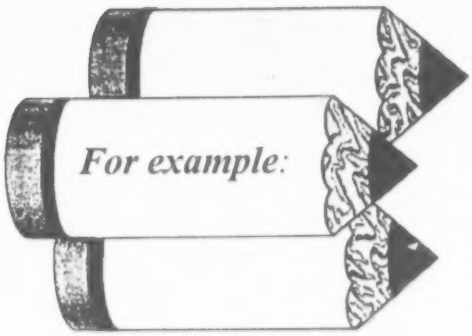
VI. Keeping Anxiety and Related Problems in Broad Perspective

Anxiety and related problems are often key factors interfering with school learning and performance. As a result, considerable attention has been given to interventions to address such problems. Our reading of the research literature indicates that most methods have had only a limited impact on the learning, behavior, and emotional problems seen among school-aged youth. The reason is that for *a few,* their reading problems stem from unaccommodated disabilities, vulnerabilities, and individual developmental differences. For many, the problems stem from socioeconomic inequities that affect readiness to learn at school and the quality of schools and schooling.

If our society truly means to provide the opportunity for all students to succeed at school, fundamental changes are needed so that teachers can personalize instruction and schools can address barriers to learning. Policy makers can call for higher standards and greater accountability, improved curricula and instruction, increased discipline, reduced school violence, and on and on. None of it means much if the reforms enacted do not ultimately result in substantive changes in the classroom and throughout a school site.

Current moves to devolve and decentralize control may or may not result in the necessary transformation of schools and schooling. Such changes do provide opportunities to reorient from "district-centric" planning and resource allocation. For too long there has been a terrible disconnection between central office policy and operations and how programs and services evolve in classrooms and schools. The time is opportune for schools and classrooms to truly become the center and guiding force for all planning. That is, planning should begin with a clear image of what the classroom and school must do to teach all students effectively. Then, the focus can move to planning how a family of schools (e.g., a high school and its feeders) and the surrounding community can complement each other's efforts and achieve economies of scale. With all this clearly in perspective, central staff and state and national policy can be reoriented to the role of developing the best ways to support local efforts as defined locally.

At the same time, it is essential not to create a new mythology suggesting that every classroom and school site is unique. There are fundamentals that permeate all efforts to improve schools and schooling and that should continue to guide policy, practice, and research.



• The curriculum in every classroom must include a major emphasis on acquisition of basic knowledge and skills. However, such basics must be understood to involve more than the three Rs and cognitive development. There are many important areas of human development and functioning, and each contains "basics" that individuals may need help in acquiring. Moreover, any individual may require special accommodation in any of these areas.

• Every classroom must address student motivation as an antecedent, process, and outcome concern.

• Remedial procedures must be *added* to instructional programs for certain individuals, but only after appropriate nonremedial procedures for facilitating learning have been tried. Moreover, such procedures must be designed to build on strengths and must not supplant a continuing emphasis on promoting healthy development.

• Beyond the classroom, schools must have policy, leadership, and mechanisms for developing school-wide programs to address barriers to learning. Some of the work will need to be in partnership with other schools, some will require weaving school and community resources together. The aim is to evolve a comprehensive, multifaceted, and integrated continuum of programs and services ranging from primary prevention through early intervention to treatment of serious problems. Our work suggests that at a school this will require evolving programs to (1) enhance the ability of the classroom to enable learning, (2) provide support for the many transitions experienced by students and their families, (3) increase home involvement, (4) respond to and prevent crises, (5) offer special assistance to students and their families, and (6) expand community involvement (including volunteers).

• Leaders for education reform at all levels are confronted with the need to foster effective scale-up of promising reforms. This encompasses a major research thrust to develop efficacious demonstrations and effective models for replicating new approaches to schooling.

• Relatedly, policy makers at all levels must revisit existing policy using the lens of addressing barriers to learning with the intent of both realigning existing policy to foster cohesive practices and enacting new policies to fill critical gaps.

Clearly, there is ample direction for improving how schools address barriers to learning. The time to do so is now. Unfortunately, too many school professionals and researchers are caught up in the day-by-day pressures of their current roles and functions. Everyone is so busy "doing" that there is no time to introduce better ways. One is reminded of Winnie-The-Pooh who was always going down the stairs, bump, bump, bump, on his head behind Christopher Robin. He thinks it is the only way to go down stairs. Still, he reasons, there might be a better way if only he could stop bumping long enough to figure it out.

We hope you found this to be a useful resource.
There's more where this came from!

This packet has been specially prepared by our Clearinghouse. Other Introductory Packets and materials are available. Resources in the Clearinghouse are organized around the following categories.

Systemic Concerns

- Policy issues related to mental health in schools
- Mechanisms and procedures for program/service coordination
  - •Collaborative Teams
  - •School-community service linkages
  - •Cross disciplinary training and interprofessional education
- Comprehensive, integrated programmatic approaches (as contrasted with fragmented, categorical, specialist oriented services)
- Issues related to working in rural, urban, and suburban areas
- Restructuring school support service
  - •Systemic change strategies
  - •Involving stakeholders in decisions
  - •Staffing patterns
  - •Financing
  - •Evaluation, Quality Assurance
  - •Legal Issues
- Professional standards

Programs and Process Concerns

- Clustering activities into a cohesive, programmatic approach
  - •Support for transitions
  - •Mental health education to enhance healthy development & prevent problems
  - •Parent/home involvement
  - •Enhancing classrooms to reduce referrals (including prereferral interventions)
  - •Use of volunteers/trainees
  - •Outreach to community
  - •Crisis response
  - •Crisis and violence prevention (including safe schools)
- Staff capacity building & support
  - •Cultural competence
  - •Minimizing burnout
- Interventions for student and family assistance
- •Screening/Assessment
  - •Enhancing triage & ref. processes
  - •Least Intervention Needed
- •Short-term student counseling
  - •Family counseling and support
  - •Case monitoring/management
  - •Confidentiality
  - •Record keeping and reporting
  - •School-based Clinics

Psychosocial Problems

- Drug/alcohol abuse
- Depression/suicide
- Grief
- Dropout prevention
- Gangs
- School adjustment (including newcomer acculturation)
- Pregnancy prevention/support
- Eating problems (anorexia, bulimia)
- Physical/Sexual Abuse
- Neglect
- Gender and sexuality
- Learning, attention & behavior problems
- Self-esteem
- Relationship problems
- Anxiety
- Disabilities
- Reactions to chronic illness